MENTAL HYGIENE

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MENTAL-HEALTH AND PUBLIC-HEALTH PARTNERSHIP*

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IF I am to speak of the possibilities of partnership between mental-health and public-health workers, perhaps I cannot do better than to begin by reminding you that we are unwittingly celebrating an important centenary in the history of public-health work. Exactly a hundred years ago this month, cholera was raging in Britain. In London the situation was particularly grave. Indeed, in ten days in August of 1854—that is to say, in about the same period during which we have come to Toronto for our meetings—more than five hundred people died of cholera within a radius of two hundred and fifty yards of the junction of Broad Street and Cambridge Street near Piccadilly Circus.

On September 7, the parish council of St. James, Piccadilly, was meeting to consider emergency measures when a stranger, a certain Dr. John Snow, asked if he might address them. Dr. Snow told the meeting that he had come to the conclusion that the disease of cholera was transmitted by water contaminated by human sewage. He went on to explain his reasons for believing that the water of the Broad Street pump was infected in this manner and he urged the parish council to remove the handle from the pump.

Although at first incredulous, the council, after discussing it, had the good sense to act on his advice. On the following day, September 8, by order of the parish council the handle of the Broad Street pump was removed. Four days later, on September 12, the epidemic was evidently on the wane.

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There are several aspects of this episode that merit our attention.

Firstly, Dr. Snow's advice was not based upon a mere whim. He had spent six years painstakingly investigating, by field studies of cholera outbreaks, his hypothesis that cholera was spread by water infected with human sewage. The facts that he had collected were sufficient to convince him that no alternative hypothesis would provide as adequate an explanation. Removing the handle of the Broad Street pump was preventive action based on a tested ætiological hypothesis.

Secondly, it was social action, the kind of action that only an organized society can take—in this case, the elected council of the Parish of St. James.

And thirdly, the ætiological knowledge on which the action was based was, as we now know, very incomplete, when we remember that even the organism concerned, the cholera vibrio, had not at that time been identified. Nevertheless, the knowledge was sufficient for effective action, and to this day the strategic significance of John Snow's incomplete ætiological discovery is such that even had the cholera vibrio never been discovered, cholera as an epidemic disease would have disappeared from the world if all nations had acted on his hypothesis. Why has this not happened? The clue, I believe, lies in the fact that this ætiological knowledge implies social action and social action of a very extensive nature.

The removal of the handle of the Broad Street pump stopped the epidemic of cholera in the parish of St. James. But it did not eradicate cholera from Britain, nor even arrest the epidemics in other parts of London. To achieve that, action of a far more widespread nature was necessary, presupposing a completely new attitude to communal water supplies and to the disposal of human sewage, and new methods of handling both. It required the development of an organized public-health service and that in turn made necessary the development of new professions—the public-health physician, the public-health engineer, and his precursor, the sanitary inspector. New laws were needed and, I may add, "laws with teeth in them." The original title of the sanitary inspector was, you may remember, the "Inspector of Nuisances," and in the early days *he* was the teeth of the law.

Nevertheless, national action ultimately did develop from

the voluntary local action of the elected council of the Parish of St. James, through the evolution of a nation-wide climate of opinion which finally created new methods of handling both drinking water and sewage and made possible legal compulsion for that minority which continued to flout, by the committing of "nuisances," the new sanitary morality that society had adopted. But the law, in fact, followed public opinion; it did not create it.

I relate this somewhat lengthy parable because I think it has important lessons for those of us who are interested in the development of the mental-health aspect of public-health practice.

Our local communities, our public-health services, and ultimately our nations will act, if we can convince them that we have ætiological knowledge on which to act and if we can spread that knowledge throughout the land; and, to be effective, it is not necessary for that ætiological knowledge to be complete.

One of our principal tasks, therefore, as mental-health workers must be to work to acquire such ætiological knowledge, and to convince those in our countries who are in a position to provide facilities for it that research to win such knowledge is the foundation stone of mental health. It is surprising that this should be so difficult when we consider the weight of the burden of mental sickness that our societies bear; but difficult it is. All concerned, whether they be in health ministries, research councils, or the governing bodies of universities, sometimes seem to conspire to ignore the fact that nearly half the hospital beds of the Western world are filled with psychiatric patients.

I suspect, for instance, that if in any Western country a single communicable disease caused hospitalization on anything like the scale that results from schizophrenia alone, a national emergency would be proclaimed. The same is true of many psychiatric problems that result not in hospitalization, but in more diffuse social damage. Adult males in need of treatment for alcoholism in several Western countries, for example, outnumber those in need of treatment for tuberculosis by several hundred per cent, and yet this problem is to a large extent ignored by most of the national and private bodies responsible for the sponsorship of research.

You will note that I am flouting current fashion by speaking of the reduction of mental disease rather than of the positive promotion of health. I do so for two reasons: firstly, because, although the mere absence of disease may not be synonymous with health, there is no doubt that the presence of disease is certainly synonymous with ill health; and, secondly, because I believe that understanding of the ætiology of psychiatric disorders, and the ætiology of their recovery, will also give us understanding of the factors that lead to positive health.

For these two reasons I feel it important that we should not allow our long-term strategic aim of promoting mental health to blind us to the tactical necessity of the reduction of ill health. If we forget the importance of the latter, we may become engaged in activities as unrelated to society's current problems as—to take an example from the field of obstetrics—training for active participation in childbirth would be to treating a pregnant woman with a contracted pelvis.

If it is agreed that the development of ætiological research, and the dissemination of knowledge that arises from it, is one of the primary aims to which the psychiatrists who support the mental-health movement should devote themselves, we must face the fact that deficiencies or biases in ourselves may handicap us in making our full contribution in this direction.

The first of these biases, which affects most of us, arises from our praiseworthy conviction that mental ill health is a grave social problem, and mental health a state for which all should strive. We are eager that others should share this view and so perhaps devote too much of our efforts to persuading them to agree with us that "mental health is very important," and too little to the more specific task of persuading the communities in which we live to take the practical steps that arise from what ætiological knowledge we have.

I should remind you that, in his discussion with the parish council of St. James, Dr. Snow's advice was eminently practical. Are we in a position, as mental-health workers, to give such practical advice based on ætiological knowledge? I believe that in a limited measure we are, but I shall leave that theme until later, so that I may comment first on another of the biases of psychiatrists that I believe damages their ability to acquire, and offer to the public-health worker, tested, if

incomplete, ætiological knowledge on which action can be based. This bias I can best describe, perhaps, as a kind of sectarianism. One cannot help but be struck by the fact that the rarest thing in the world is a general psychiatrist—and here I should interpolate that, in the realm of ætiological knowledge, I make no excuse for considering the psychiatrist the key member of the mental-health research team, although later, when I come to consider action based on that knowledge, I shall suggest to you that in that field his position is by no means so central.

I should perhaps explain what I mean when I describe the general psychiatrist as a rarity. I do so because I would find it very difficult to think offhand of enough psychiatrists among my acquaintances to outnumber the fingers of both my hands who are equally interested in current developments both in psychoanalytic and in neurophysiological theory, in the study both of the psychoneuroses and of the psychoses, in the study of children both of normal and of subnormal intelligence, in the study both of a clinical case and of the epidemiology and genetics of the same type of disorder in the community, and, by no means least important, in the attempt to keep reasonably abreast of developments in the various fields both of the behavior sciences and of mammalian biology, all of which must ultimately prove to be components of a true and comprehensive human biology, of which psychiatry is, whether we like it or not, a part. There are, of course, psychiatrists who are outstanding exceptions, but they stand out by their rarity as well as by their scientific stature.

Why do I consider this sectarian tendency of our profession such a handicap to our ability to contribute ætiological knowledge on which public-health and social action may be based? It is because it flies in the face of the very conception of ætiology itself. We no longer live in the naïve and optimistic age of Koch, when ætiology was believed to lie in "the single specific cause." The study of ætiology, as we now conceive it, is the unraveling of a web woven of many threads. Different threads within this web are most fruitfully traced in different areas of psychiatry, and often by methods drawn from other disciplines. Each in turn leads to other fields, for the study of which the methods of yet another discipline, applied in yet another area of psychiatry, may be most appropriate.

This sectarianism to which I have referred may be no handicap to the psychiatrist who restricts himself to clinical work in a specific sector of the psychiatric disorders—although I would be tempted to challenge that assumption had I the time—but for the psychiatrist interested in the mental-health field, in the pursuit of ætiological knowledge, and in the preventive action that must be based upon it, it is, I believe, a form of crippling myopia.

In reminding you of Dr. Snow and the Broad Street pump, I pointed out that, on the basis of partial ætiological knowledge, it was possible for him to advise, and for the community to undertake, local action that was both rapid and effective. But I indicated also that the national implications of that knowledge were so widespread that they reached into every corner of the nation's social life. To act nationally on those implications needed many simultaneous changes—a widespread modification of popular beliefs on drinking water and human sewage, the evolution of new methods of handling both, the passing of new laws, the creation of a public-health service, and the training of completely new types of worker for that service. Each of these changes at every step needed the vigorous advocacy and support of a group of devoted public-health reformers. I believe the same to be true in the mental-hygiene aspects of public-health work. So that whereas, in the local community, action based on ætiological knowledge may be comparatively easily achieved, this is far from true of action on the national scale, for the latter will entail radical revision of many aspects of the social fabric and the practices of the whole society.

Perhaps one might illustrate this by taking a single hypothesis regarding a factor that has been suggested as making a significant contribution to the prevalence of certain types of psychiatric disorder, and by following through all the implications of that hypothesis for action on the national scale.

Let us take as our example the hypothesis that an infant between the ages of six months and three-and-a-half years needs a continuous relationship with a mother or a mother figure, and that children deprived of such a relationship during that period will show, more frequently than those who are not so deprived, a degree of permanent damage of personality development—damage particularly to the capacity

to form relationships with others and to the cognitive capacity we call abstraction.

If we were to accept such a hypothesis as valid, and if we were called upon to collaborate with our public-health colleagues in acting upon it, we should have to start by considering two questions: First, do the practices of the public-health services tend to bring about such separations and, if so, how can they be avoided? Secondly, what are the other social causes of such separations and what must be done to prevent them?

In considering the first question, we are, I think, forced to admit that we in the medical profession are responsible for many of what I might call the "elective" separations of young infants from their mothers. We have given far less consideration than it merits to the devising of domiciliary care for many chronic maladies for which we are accustomed to put infants into hospital. We advocate the advantages of wholesale hospitalization for childbirth without weighing in the balance its disadvantages. We deal with the problem family by the radical surgery of removing the infant from it to an institution.

As these few examples show, to take seriously the implications for action of the hypothesis of the noxious influence of the separation of the young infant from the mother demands a wholesale revaluation of many of our public-health practices. Nevertheless, as is now being shown in many different places, changes in public-health practice that reduce the frequency of these "elective" separations can be achieved at the local level. For, as Dr. Snow found in his meeting with the parish council of St. James, face-to-face discussion with those who have a direct responsibility for the health and welfare of their immediate community can bring about understanding of the need for change in that community and, understanding once reached, action can be prompt.

But the effects of such local action are limited. The removal of the handle of the Broad Street pump had no immediate effect on the cholera that spread from the many other infected sources of water in other parts of Britain. And yet in time its wider effect ultimately began to be felt, chiefly through the spreading appreciation that arose from it of the general proposition that the radical prevention of cholera depended

on keeping sewage out of drinking water. But this, as is evident, demands far more comprehensive action than the removal of the handle of a pump. The latter measure was within the competence of a parish council, but the former required the concerted action of the whole health organization of a nation. In this respect we are luckier than Dr. Snow and the early public-health workers who followed him. They even had to create the national public-health organization.

But to return to our hypothesis of the ætiological significance of the infantile-separation experience. Even supposing that we and our public-health colleagues prove successful in so modifying public-health practices on the national scale that they no longer contribute their present considerable proportion of the separation experiences that are inflicted on infants, we would still only have begun our task of acting on the implications of this ætiological hypothesis. For looking round our societies, we shall immediately see a large variety of social phenomena, beyond the bounds of public-health practice, from which such separations arise. Illegitimacy is an obvious example.

There is clearly an ætiological problem here, and it is extraordinary how little serious research work has been done on the socio-psychological ætiology of illegitimate pregnancies.

Radical prevention of separations arising from this cause must await such ætiological understanding. But, in the meantime, even though we lack that knowledge, we do know what usually happens to illegitimate children unless we take steps to prevent its happening. They form, in many countries, the largest single group of "separated" infants. It is they, rather than orphans, who fill the orphanages. How can such children, having been born, be provided, during the period considered important, with a continuous relationship with a mother figure if their natural mother cannot care for them?

Adoption seems to be one obvious answer and yet the recent survey of adoption legislation by the United Nations shows that the laws of many nations, far from facilitating the provision of a maternal relationship at this critical age, in some cases actually forbid it. In fact, one is tempted, when one studies the laws on this subject, to conclude that they are framed to protect adoptive parents against the awful poten-

tial danger of adopting a child, rather than to fill the infant's biological need for mothering.

In another large group of unmothered infants, we shall find that divorce is the factor that led to the separation, and we shall be forced again to note an extraordinary absence of research on the ætiology of the breakdown of marriage. Even without that knowledge, however, many separations arising from divorce would not occur if the divorce laws in some countries did not include the perverted notion of using removal of the child as a punishment for the so-called guilty party, or his custody as a reward for so-called innocence.

We shall be forced, too, to consider other influences of an economic nature that force the mother to leave her young infant in order to work. Among these I would quote as an example the influence of a conscious national policy that sets out to put pressure on such a mother to work in a factory in the interests of an increased labor force. The income-tax policies of many countries also are such that inadequate tax allowances for children force many mothers of young infants, whether they wish to or not, to work to supplement the family income, while the childless married woman, free of the economic pressure of a family, can stay at home. The policy of "equal pay for equal work" has the same effect, unless generous children's allowances for those who wish to mother their own infants balance the pressure to go out to work. Equal pay for equal work—in the absence of such children's allowances—means that the woman who stays at home to mother her infant considerably reduces the family's income. Those are only a few of the ramifications of the problem. If time permitted, we could follow its implications much further.

I have taken this one ætiological hypothesis and tried to trace a few of its implications for action throughout a nation. I hope I have demonstrated that they are quite as far-reaching as those that ultimately arose from John Snow's hypothesis about the effects of sewage in drinking water.

At this point you may be prevoked to interject, "I don't accept the validity of the separation hypothesis." In that case, rather than pursue the attractive red herring of attempting to decide whether you reject it because of its implications or as a result of a scrutiny of the evidence offered in support

of it, I would invite you to take any other item of ætiological knowledge you may choose and follow through all its implications for social action. They will prove equally far-reaching.

And you will see that the implications for action may reach not only throughout the direct activities of the public-health services, but far beyond, into every corner of national social organization and policy. They will lead you even to consider matters of legal and fiscal policy that at first sight might seem very remote from mental hygiene.

We should not be daunted, however, by the immensity of the range of these implications. However difficult it may be to bring about immediately the action they call for on a national scale, we are certainly not powerless to bring about some appropriate action locally in the communities of which we are members, from which ultimately will spread the general understanding that leads to national action.

When earlier I spoke of the need for ætiological knowledge, I suggested that the psychiatrist was probably the key member of the research team to which we must look for the acquisition of that knowledge, although I indicated my belief that many of the techniques of study he must use would probably have to be drawn from disciplines far beyond the bounds of clinical psychiatry. I do not believe the psychiatrist plays anything like such an important rôle in the preventive action that arises from the ætiological knowledge he acquires.

This relative insignificance of the clinician is a characteristic of preventive medicine in action—and it may be one reason for the hostility felt toward that branch of medicine by those clinicians who overvalue the privileged and priestly origins of their profession. Although it was the clinician and his colleague in the clinical laboratory who won the ætiological knowledge that makes, for instance, the prevention of typhoid possible, they play little part in preventing it. For our freedom from this disorder in the Western world we rely on the generalship of the public-health physician, not the clinician, and equally on the unending campaign fought by the men who operate our water-filtration plants and our sewage systems, by those who handle and distribute our food supplies, and by many other groups of non-medical workers in our society. And last, but by no means least, we rely on the

mothers and teachers who transmit to each generation of children the personal habits that our societies adopted, rather recently, as one of the long-term results of the startling hypothesis which John Snow first put forward that feces in drinking water can give rise to ill-health.

You may wonder why I again flout the present-day fashion in speeches on mental health by putting mothers and teachers last on the list. I do so because, in the earliest stage of preventive medicine, at which mental hygiene now stands, mothers alone cannot take the action that is needed. I believe we have done a disservice to mental hygiene by repeatedly telling mothers that they are predominantly responsible for the mental health of their children.

It is as if John Snow had advised the mothers of Broad Street to stop the epidemic by teaching hygienic habits to their children. Not only would the epidemic have continued, but in addition the mothers would have been blamed, and would have blamed themselves, for their failure to arrest it.

It was far more important that the women of Broad Street should understand and accept the reason why they had to walk further to fetch their water when the handle of the pump was removed. In other words, at that stage of the problem their understanding and action *as citizens* was needed, not their action in their personal capacity as mothers.

It was later, when communal action had removed the all-pervading threat to health of an infected water supply, that their action as mothers became more important than their action as citizens. Once safe water was available, the mothers' personal action in teaching to their children the new sanitary morality played an important part in combating the "person to person" infections that still remained.

The way in which this new sanitary morality of the 19th century was spread throughout the community prompts me to reflect that we in the mental-health movement sometimes seem to feel that we are the first discoverers, and the most skillful practitioners, of the health education of the public. It is not until we see the sensitive community-health-education experiments of present-day workers in public health in different parts of the world—let alone some of the educational ventures in the field of agricultural extension, fundamental

education, or community development—that we realize that we are not the only partner to bring to this enterprise the capital of knowledge and experience in this field. In addition, we must realize that the partnership can be successful only if we set out to understand and share the traditions, the methods, and the aims of the public-health worker, and it is here that so often we as psychiatrists have failed. Our failure has rested as much on an absence of humility and of understanding of what preventive medicine is and does as on the relative paucity of our ætiological knowledge. Our future contribution to the partnership will depend on our determination to remedy both these deficiencies.

When it comes to wider changes in society beyond the actual conduct of public-health practice, we shall find again that such changes are far easier to achieve in partnership with the organized service of preventive medicine than they are by mental-health workers alone. For from its outset, one hundred years ago, preventive medicine has been concerned, not merely with direct public-health action, but with the promotion of health through social changes that remove noxious influences from the human environment or provide for biological needs that were previously unfilled.

In the past the great successes of preventive medicine have concerned the physical health of the individual, and it has been the improvement of the physical environment and the filling of physical needs to which the public-health worker has devoted his efforts. As the frontier of preventive medicine moves on to the problems of mental health, his attention must turn—indeed it is already turning—to the psychological and social environment and needs of the human being. If preventive medicine is to be as successful in this new territory as it has been in the old, it will need from us ætiological knowledge on which to act and a true working partnership in that action.

Some of the main supporters of preventive medicine, as it began to develop a hundred years ago, were physicians, but so, I must remind you, were many of its principal opponents. I have no doubt that the profession of psychiatry will display the same two-faced attitude toward preventive medicine as it begins to occupy itself with the problems of mental health.

Nevertheless, I am sure that there are leaders in the practice of public health who will be as little deterred by the sneers of those who belittle their efforts in this new field as was John Snow by the almost unanimous rejection by his medical contemporaries of his ludicrous hypothesis regarding the ill effects of fecal contamination of drinking water. I am equally certain that there are, and will be in the future, other psychiatrists who will enter into a partnership with their public-health colleagues that will ultimately result in victories over mental ill health as great as those over physical disease that stemmed from John Snow's advice to the parish council of St. James, a hundred years ago, to remove the handle of the Broad Street pump.

SOME OBSERVATIONS ON AMERICAN PSYCHIATRY[1]

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FOR people who come from abroad, even from the same continent as I do, South America, it is amazing to observe how fast American psychiatry is being developed. First of all, what strikes us most is the keen interest of public opinion in mental health. Radio, television, theater, movies, newspaper—all the common means of communication in the United States stress very often the importance of our specialty for routine everyday life.

Research is the biggest concern for psychiatry in this country. Everything we are doing in South America in this field represents only a small fraction of your huge efforts in investigation. Even in the best centers of great cultural tradition in Europe, we do not see the amount and quality of psychiatric research that is easily found everywhere here. I believe I am not wrong in my impression that in almost all your seventy or eighty medical schools, and surely in more than one-third of your six hundred mental hospitals, some kind of research is being conducted at this moment.

All the schools of thought in psychiatry are flourishing here and live together very harmoniously, each one doing its best to secure wider acceptance of its own points of view. The organicists are just as devoted as the other scientists on the psychodynamic or psychosocial sides. Looking broadly over the field, we get the impression that the psychodynamic orientation is growing steadily, with more and more followers every day.

The teaching of psychiatry constitutes one of our great differences from you. In South America the subject is in the curriculum of the medical schools for only a one-year period,

[1] Presented at a round-table meeting on "Cultural Patterns in Psychiatry" at the One Hundred and Tenth Annual Meeting of the American Psychiatric Association, St. Louis, Missouri, May 3–7, 1954.

very exceptionally for two years, whereas in the United States it is very common to see the teaching extended to the whole four-year period. Internships and residencies are taken very seriously here and contribute enormously to improving professional skill. We do not have residencies nor have we established yet a Board of Psychiatry and Neurology.

I believe that cultural differences have some influence on the formation of patterns of mental care and probably on the presentation of mental symptoms. We know very little about this, and we will have to start research in this field, for we have been wondering about some of the curious features presented by our patients. In the United States, for instance, you do not have to worry any longer about general paresis, since the discovery of penicillin. But we do. Psychosis due to syphilis constitutes still a heavy burden on our mental hospitals, representing nearly 8 to 10 per cent of all new admissions. Since 1925, soon after Wagner Von Jauregg advised malario-therapy for general paresis, we have worked intensively with this new kind of treatment. We built a special Institute of Neurosyphilis in Rio de Janeiro, which is still in full operation with 250-bed capacity and a good strain of malaria. The Juquery Psychiatric Center in Sao Paulo State has a large 300-bed unit for the same purpose. Why malaria there works better than penicillin we do not yet know. The fact is that our psychiatrists prefer malaria because, with this treatment, there is less chance of relapse.

Depressive states are responsible for a much lower number of suicidal attempts in our mental hospitals than here in the United States. I do not have the statistical figures on hand, but we know by experience that such occurrences are very scarce there. This fact is also mentioned by an American professor of psychiatry, Dr. Edward Stainbrook, who recently visited my country doing research in schizophrenia and was surprised to learn about the very low rates of suicidal attempts among mental patients.

What can we say about behavior patterns of agitated patients? I would hesitate to advance any statement without having been engaged in comparative research in different countries. One of your most outstanding professors of psychiatry, Dr. F. C. Redlich, of Yale University, in talking about

his experience during a recent trip he made to Korea, Japan, and Okinawa, mentioned that he was very much impressed by the quietness and orderliness observed in the wards allocated to acute and disturbed patients in state mental hosptials in Japan. He did not see many noisy, talkative, and hyperkinetic patients, as he had expected to. Dr. Paul Lemkau, who has given us his impressions about Japan, said almost the same thing about the so-called disturbed patients. He relates that peculiar feature to the greater number of personnel available in Japanese hospitals. Perhaps he is right, but we had better start some research about it.

Regarding the same matter, I want to tell you a story that sounds like a joke, but it really happened. Two years ago, having been promoted to the high rank of bishop in the Catholic hierarchy in my country, an intelligent priest friend of mine, who had held for years the responsible job of executive secretary for the entire archdiocese, was anxious to complete his report before leaving the office and at the same time to prepare the ceremonial speech he had to deliver when assuming his new duties. He was looking for a quiet place where he could work undisturbed. At my invitation, he came to spend twenty days secluded in our 1,000-bed state hospital. When he left the place, he was happy to express his feelings by saying to everybody: "What a discovery! I never realized that a mental hospital is the quietest and most relaxing place in the world when we need peace of mind."

The ratio of nurses and attendants in American hospitals is higher than in other countries, particularly if we compare the figures with Europe and South America. We must congratulate you, although even your figures are not high enough yet, according to the standards recommended by the American Psychiatric Association, whose goal is nothing less than near perfection.

About standards, we feel that what you Americans have been doing toward improving mental-hospital conditions over the last ten or fifteen years is really wonderful. The work of the Mental Hygiene Division of the Public Health Service has been supplemented by the American Psychiatric Association office in Washington, D. C., with careful surveys and inspections that are contributing much to raise hospital standards.

The American Psychiatric Association, as a private or professional organization, is joining the federal influence as a legitimate catalytic force, acting in ways appropriate to its own prestige and acceptance throughout the country.

As to psychiatric orientation, we observe that psychoanalysis in the United States is spreading rapidly. The number of institutes for teaching psychoanalysis and of people engaged in psychoanalytic treatment, not only in private, but also in public institutions here, is much greater than in any other country.

With regard to the mental-hygiene movement and to child psychiatry—two fields in which you have indisputable leadership—we foreigners have not much to say, but only to see and learn. Prevention is a concern so important to everybody that we cannot separate child care from our other mental-health activities, having always in mind that a healthy childhood is essential if mental disturbances are to be avoided.

All the people in your country should be proud of the achievements of American psychiatrists, psychologists, social workers, socio-anthropologists, neurophysiologists, and all the many other soldiers and generals in that big army that is fighting for mental health in a way that has so greatly magnified the scientific position of our New World.

We hope our American colleagues will continue on the same journey with enthusiasm and devotion, strongly supported by all the responsible men in the government and in the community, and having always behind them the warm interest of the public itself, which is the direct recipient of all the good resulting from this great movement toward better mental health.

THE RÔLE OF NATIONAL ASSOCIATIONS*

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PICK up the New York telephone book and turn to the letter "N." After the word, "National," you can find the following twenty-one different words that indicate some form of human association—national association—for one purpose or another. As you hear this list, please note the flavor and the connotation that each of these words conveys. Before each comes the word, "National": Academy, Alliance, Association, Authority, Board, Bureau, Club, Committee, Conference, Council, Federation, Foundation, Guild, Institute, League, Legion, Organization, Registry, Service, Society, and System. Will Rogers once observed that an American was willing to join almost anything but his family. But these names are not the names of anything. They are not even synonyms. They are not equivalent. Each has a special flavor of meaning to each of us, and probably no one of these words means exactly the same to all of us. Such a formidable choice of names poses my subject in the form of a question: What is the rôle of a national association?

In the first place comes the fact that these names all share the adjective, "National." I suppose that this offers but another instance of the fact that we live in an era of intense nationalism, so the word, "National," reassures us all, suggesting unity, loyalty, safety and power, scope and influence, largeness if not grandeur. In other countries and other centuries some other adjective than "National" has held similar sway—"Royal" "Imperial," "Holy," or "Roman." But to-day the word is "National," and in that magniloquent word I think I am right in suspecting the chance of a trace of self-deception, precisely because we like the flavor of what is called national, for few of us are free from the human frailty so neatly ticketed in the French phrase, *"Il se paye en mots"*—

* Presented at the annual banquet of The National Association for Mental Health, New York City, October 24, 1954.

"He rewards himself in words." Sleight of hand hides little to compare with what sleight of tongue conceals.

Edmund Burke said that when you find a concealment, you make a discovery. In any event, this momentary pause over the word, "National," leads to the recognition of two types of national organization. These types are not mutually exclusive; they usually march on each other and at times overlap or blend. So perhaps it would be better to say that national organizations present a graded scale or gradual spectrum, whose two extremes have the following characteristics:

At one end are those national associations whose purposes and interests are so specialized, and whose protagonists and champions so few, that only by drawing upon the whole nation can they hope to assemble an effective band of enthusiasts. Hence the word, "National." Their purpose is to stimulate a nationwide interest in their programs, to advertise, to evangelize and make converts. Their leaders are usually self-appointed and sometimes even self-anointed, for almost no electorate exists, since followers are still to be found or even made. Local chapters do not exist; the need for them exists, but they are not yet in being. Such pioneering national organizations seek above all to stimulate and create.

At the other end of the scale there are national organizations with a quite different major task. Their major function and purpose is to coördinate a group of already existing agencies, local chapters, or constituent societies. They take such names as federation, alliance, or league. Their purpose is to serve their constituent members, reconciling internal differences, protecting their collective interests, and providing a forum or mouthpiece to express the consensus of their members' views.

Each of these extreme types shows the defects of its qualities. On the one hand the lonely pioneering zealots are likely to suffer from the limitations of extreme individualism and the vagaries and vicissitudes of unreflecting independence. Their contributions to their cause, though daring and sometimes noble, remain all but unorganizable, so personal are they, so emotional, fitful, unpredictable, and radical. They improvise because they are in a passionate hurry, for all too often they cannot survive the death of their founders. In contrast, the other type—the federations—tend to conserva-

tism and compromise, subservient at once to their electorate and to the past. Their leaders resemble cautious moderators more closely than intrepid pioneers. Obviously these extremes have each great merits; we can express no preference.

But beneath both these characteristic forms of behavior, what is the *raison d'être,* the ultimate and common justification, the essential vitality of national associations? It is this: in a democratic society we citizens as mere laymen can exercise, individually and by association, the eternal vigilance that is the price of liberty. We do not have to leave what interests us to the experts or to a government bureaucracy. We do it ourselves—amateurishly perhaps, but by ourselves. That is both the privilege and the price tag of living in a democracy. It has been neatly observed that he who knows *how* will always find employment and he who knows *why* will be his employer. In a democracy we rely upon the citizens to know *why*—to be the employer. As a result our national associations by their mere existence accomplish an act of faith —one might say the superlative act of democratic faith. They exemplify the belief that leadership depends on the followers, not on the divine right of kings, or dictators, or specialists, or administrators, or anything as narrowly logical as efficiency. In essence a national association disputes the finality of any control from above downward. The strength of a national organization lies in well-informed participation that is steady, but imaginative. Napoleon held that if you want some public service done well, get experts to do it, and then get intelligent layment to say whether or not it has been well done. This same layman's judgment I look to be supplied first by national organizations and—often at long last if at all—by the electorate at the polls, for a conviction widely enough spread may well find utterance in legislation.

If the justification for such efforts as national leagues, associations, bureaus, conferences, and so on, relates to the preservation of your liberty, what considerations may best decide which of so many organizations you will choose to work in or belong to? The deepest need of any organization is to be needed. Perhaps, therefore, you may well select those societies that try to meet the needs you feel most deeply.

The depth of feeling regarding mental health, the convic-

tion that infuses the membership of your organization—The National Association for Mental Health—distinguishes you. Most other people who have had close contact with mental disorder react to it with panicky aversion. And most of those who have had no such contact avoid or evade or ignore the subject entirely. Your realism and courage do you honor. I know that some of you, and I could hope that all of you, have enough historical perspective to realize that mental diseases afflicted the human race long before cures were found and long before the nature of the disease was understood. But you show courage in facing the fact that a similar distressing ignorance will continue unchanged unless those of us who feel the call do something about it. "Hope deferred maketh the heart sick"; it may be a long road to follow, and there will be those who will fall out, discouraged or even angered by frustration. The task is really hard—so heroic that I cannot find it in my heart to blame those who do not always match their hopes with patience and tenacity.

Sometimes I wonder whether membership in national associations of the pioneering type might not wisely be limited to three years, in acknowledgement of the usual duration of human enthusiasm for truly difficult undertakings. And then, after this probationary novitiate, could come the opportunity for reënlistment, as senior members, for our more tenacious characters, our more distinguished and devoted citizens.

In any event, national organizations that have really difficult and discouraging tasks must see to it that their members get a sense of significant participation as individuals in something great. Indeed some serious, but probably productive study might be devoted to the question, "Whence comes real satisfaction to our membership?" With radio, TV, movies, ball parks, stadiums, congressional investigations, and spectacles suported by advertising or government, we have become a nation of spectators with hardly better than a 15-minute span of attention, hypercritical and hard to please, attentive only to superlatives, to horror or amusement.

If we seek to know whence comes real satisfaction to our membership, let us look at ten kinds of activity characteristic of national associations. Somewhere in the list nearly every one of you could fit in, contributing your talents and experi-

ence, not as mere onlookers, or passive stockholders in affairs run by "the management," but as participating members.

A national association can do the following:

1. Inform the public and focus attention upon the present state and the potentialities of the association's chosen field. It can give advice on request. In George Stevenson's skill and wisdom as an adviser you have an excellent record and example of this advisory function.

2. Stimulate the creation, and aid in the formation, of local chapters—state, county, and city—of the national association.

3. Inform and encourage members by holding at least one general meeting a year, and by the maintenance of a journal and a central reference library with an active lending service.

4. Initiate or sponsor studies by staff or even by members—studies related to the chosen field—and distribute the reports thereon.

5. Foster and support research done by others. In the choice of research projects I would beg that you give deliberate attention to the balance between the gilt-edged and the speculative—to use the phrases of an investment portfolio—for that distinction deserves attention. And I would also beg you to help in the search for causes of disease, for without knowledge of causes the task of prevention becomes haphazard and discouraging.

6. Standardize the qualifications of persons engaged in the types of work supported, facilitate recruitment in every possible way, and when necessary maintain a registry of well-qualified personnel to be employed in special fields.

7. Coördinate the field with others related to it; avoid preciousness and isolation. None the less, protect the field from encroachments by others who appear ready to ignore or sacrifice or even attack the work in hand.

8. Collaborate with government and tax-supported agencies. For example, legislatures have been known to appropriate large sums for the control of disease, but nothing whatever for finding out how best to do it. Government officials are often the first to recognize and appreciate non-governmental organizations—especially if such organizations decline to boast of their own accomplishments in contrast with occasional governmental limitations, mistakes, or ineptitudes.

9. Raise funds for the association's budget. The Dean of the Faculty of Arts and Sciences at Harvard, McGeorge Bundy, recently said, "The excellence of Harvard is not in the first instance a product of its financial resources. Fundamentally its resources are the reward of its excellence." It is a pleasure to quote some one else in point of one of the more austere of my own convictions. And I would add that I found long ago, when I used to be told that a situation "presented a real challenge," that all too often the use of that word, "challenge," meant merely that there was a deficit. From such a sad fact I would offer the—I hope, not too blunt—opinion that a record of high performance offers more challenge to a wise donor than does a deficit.

While we are on the subject of finances, I would offer the simple calculation that an organization that sets aside 5 per cent of its annual income as endowment to pay interest at 4 per cent will, if its annual income is $30,000, reach an endowment income of $1,400 annually after twenty-five years, even without compound interest. What size of stable

income you would have to-day if you had begun twenty-five years ago such a 5 per cent sequestration of your annual income, I don't know—and perhaps it is too painful to elaborate. But it would be large and dependable. The tasks of this association will not be completed in the next fifty years, and some such sequestration of income might serve to remind you that you seriously need some dependable continuing endowment income.

10. Increase membership—especially in local chapters. The Red Cross has an admirable history—of getting membership of this decentralized and widely shared kind.

After this brief review of what a national association can do and actually does accomplish, let me turn to the criteria that may be applied by any national organization with the idea of self-improvement. These criteria may be internal or external—questions properly asked inside the family, as it were, or likely to come from the outside.

Within the organization, what would you say of the quality of your communications with each other—written and spoken? It is a question simple in form, applicable to each member, and always a point where improvement can be begun at any time by any one.

I refer to the cardinal qualities of communications of any sort—frequency, brevity, completeness, promptness, and sincerity. In many organizations the letters and conversations are rare, but long and verbose, incomplete and hastily composed, reluctant and delayed, and—for reasons that cannot be justified—sometimes lacking in candor.

Next, do your officers—not the executives, but the elected officers—really know what is going on? And have you trustees who have the time and the ability to brood upon the affairs of the organization, upon its potentialities as well as its policies?

On the subject of budget I have already mentioned the importance of endowment income. For the year ended September 30, 1953, your interest income was only $263.84 out of a total income of $586,631.47. That seems to me extremely small, for it is only forty-four thousandths of 1 per cent. As for temporary support, experience has shown me more than one example of the risk to any national organization of depending on any one source for more than one-third of its total income. And I might add that I have come to that opinion slowly and reluctantly. I am still nettled by a wry definition I heard years ago of a national association as "an outfit whose head is in the clouds, whose hands are in the air, whose foot

is in the door—and supported by the Rockefeller Foundation." There are times when the well-known analogy of priming the pump proves to be exactly that—and initial help from a foundation is justified. But the pump-priming argument has something glib about it unless the most conscientious attention be given to making the pump work afterward, for that is where the justification lies. In other words, pump-priming, though a neat figure of speech, describes a great obligation.

Is your membership growing? What is its turnover? What is the age composition of your membership? What is its trend—toward an older or a younger membership? What studies have been made comparing this association's membership with that of other national organizations? Are the possible activities open to members made vividly clear to your new members? How are the services given by your members acknowledged? Is a significant bit of service sure to be recognized? Or do you have the trouble of a church I used to know, whose members were described as "worshipping the Lord with a cross on one shoulder and a chip on the other"? Does the unselfishness of your ends excite, or even excuse, jealousies and vanities in the members in attaining those ends?

Let us turn from soul-searching to what may be said or thought by others about you. From the outside, the effectiveness of a national organization may be judged by how widely and accurately its work and purposes are understood and supported by the public; by the character as well as the size of its membership; by the excellence of its studies and the range and reliability of its information services; by the measure of pioneering in its programs as well as the quality and continuity of its routine services; by the growth and quality of local chapters and the help given them by national headquarters; and—an item often ignored—by the extent to which the national organization gives to the local chapters and even other local groups the credit for progress made.

Obviously the annual report of a national society or league deserves careful consideration. I have come to feel that short reports are better than long ones. This is not because they are easier to read, but because short reports can reveal excellent work, but cannot hide the lack of it. You can cover any cadaver if you have plenty of sheets—of paper. In these

times of ignored, but undeniable inflation, an annual report might well contain a table showing the loss of purchasing value of the dollar, and the correction to use in comparing the actual purchasing value in to-day's dollars of every budget back to 1915. If allowance were thus made both for the loss in the purchasing value of the dollar and for the steady growth of our national population, we should, I suspect, stare at each other in surprise at the shrinkage of per-capita support for many of our national organizations.

I have offered you some comment on the nature of national associations, their intimate relation to democratic citizenship, the range of their work and purposes, some ten of their major activities or potentialities, and some of the criteria by which they can be judged both from within and from without. I offer all of this in the mood of an old French friend who said, "Remember, my boy, you can have anything you want in this world, only don't forget to pay for it." The psychology of high endeavor is a subtle matter, and we can wisely bear in mind what has been said of the alcoholic—he doesn't want to stop drinking; he only wants to want to stop drinking. In short, you are what you are; it is not enough to want to want to do better, for accomplishment must be paid for in another currency than that of appearances.

Perhaps these comments have seemed too analytical and matter of fact, too lacking in emotional resonance and fervor. If this organization were devoted to some abstract principle like the single tax, or even a purpose as concrete as the reduction of our high tariffs, then another kind of address might have been in order. Far more stirring and eloquent than any words, there stands, at no impossible distance from any of us, a mental hospital we could visit for one whole day. From the agonized compassion renewed by one thoughtful visit, we could obtain enough emotional drive to take us through another winter in steadfast conviction of the value of this National Association for Mental Health.

SOCIAL REALITY AND PSYCHOTHERAPEUTIC IDEALS

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FROM Freud onward, systems of psychotherapy have always contained explicit or implicit assumptions concerning the nature of man and his place in society. These assumptions tend to reflect not only the personal philosophy of the psychotherapeutic innovator, but also the values of his social group and the climate of his times. Thus, Freud's emphasis upon the recovery and expression of repressed material appears to represent his dedication to human liberty. On the other hand, his feeling that basic human impulses are antagonistic to constructive social living seems to echo the morality of the Victorian era.

Subsequent theoreticians of psychotherapy, regardless of the extent of their deviation from Freud, also have built their views of men and society into their "schools" of psychotherapy. While such an integration is inevitable, it tends, unfortunately, to distort the psychotherapist's perception of some of the actual forces that determine the reactions of patients to the ongoing therapeutic situation. In short, patients and therapists often live in different social worlds. The greater this difference, the greater is the possibility that the therapist will not accurately perceive the implications of much of the patient's behavior. Because of such misperceptions, the therapist may doggedly pursue goals in such a way as to fail to take adequate account of the limitations that social reality imposes upon the patient's will to achieve those goals. When this occurs, a favorable therapeutic outcome is impeded, if not precluded.

In view of the problems that may arise from a failure to coördinate therapeutic ideals with social realities, it may be useful concretely to illustrate how institutionalized social practices may impinge upon the individual patient in such a way as to limit, directly or indirectly, his participation in the

psychotherapeutic goals that the therapist hopes to implement. To crystallize this point, we have selected case material from a psychotherapeutic experience with a Negro, since, in our culture, certain aspects of social reality clearly limit the Negro patient's ability to fulfill some of the basic goals that are inherent in the therapeutic endeavor.

Without attempting to deal with the fine nuances of differences, we feel secure in asserting that most contemporary schools of psychotherapy would accept, as fundamental, the following treatment goal: to help the patient *maximize the appropriateness* of his emotional and behaviorial reactions to any given situation. Of course, even under optimal circumstances, this goal can be only approached rather than perfectly attained. Nevertheless, conditions of Negro life in America are such that the needs of survival often not only block movement toward this therapeutic ideal, but actually impel the Negro in a counter direction. In fact, for the Negro patient, progress toward increased appropriateness of response may become, paradoxically, more difficult as he improves in other respects.

Generally, as a patient begins to develop greater self-assurance and security, he may be expected to air more of his thoughts and feelings. Furthermore, with added self-respect, he tends more consistently to defend his rights and to resist manipulation and humiliation at the hands of others. If therapy proceeds successfully, these changes will occur in Negro patients as well as in white ones. However, the improved Negro patient often achieves a level of self-respect that, although not extraordinary *per se,* may place his very life in jeopardy. When this level is reached, a therapeutic crisis is likely to ensue because the patient is faced with the necessity of choosing between exceedingly dangerous behavior that is consonant with a striving toward appropriateness and behavior that enhances the chance of survival, but that is distinctly inappropriate as defined by the therapeutic ideal. If handled properly by the therapist, the crisis passes and further constructive work is possible. If, however, the therapist's vision is too obscured by his theoretical preconceptions, his relationship with the patient may deteriorate, leading not only to the indefinite suspension of therapeutic progress, but even to the eradication of previous gains. In the following

case presentation, we shall describe the unfolding and resolution of such a crisis.

George is a light-skinned, amber-eyed, twenty-two-year-old Negro, of average height and athletic build. He was reared in an upper-middle-class Negro family whose home is in the Deep South. Both his parents are college graduates, his father being a successful physician with a large private practice. George has three siblings, a younger sister and an older brother and sister.

In the course of his life, George has been subjected to the usual forms of degradation that are imposed upon Negroes in the South. Moreover, George's father is a cold, dominating, and implacable family tyrant whose treatment of George reinforced the humiliating effect of the general social situation to which George was exposed. George's mother, although far less punitive and domineering than her husband, favored George's older siblings and, consequently, tended to contribute to the negative self-image that George acquired. Thus, George's personal security and sense of worth were severely impaired by this negative combination of familial and social influences.

Overtly, George was very docile and self-effacing. He found it impossible to assert his own needs in the presence of authority figures, either white or Negro. He would permit himself to be pushed into actions and situations for which he had no spontaneous desires. Basically, then, George felt helpless when faced with an interpersonal situation in which some one was trying to coerce him.

Beneath the surface, George secretly nurtured a staggering amount of hostility. Much of the time his elaborately destructive fantasies made it impossible for him to attend to tasks at hand. He was almost addicted to dreams of vindication and triumph over all persons before whom he felt compelled to humble himself. These vicarious expressions of resentment helped to sustain him in the midst of his suffering.

On the side of constructive aspirations, George envisioned himself a leader of the Negro people, defending their civil rights and promoting their welfare. Indeed, he had made several sporadic attempts to express these inclinations by doing volunteer work for Negro welfare organizations. On

one occasion, several years before starting psychotherapy, George agreed to be a test case in a civil-rights action against a railroad that practiced discrimination south of the Mason-Dixon line. In this case, however, George played the rôle of a passive victim rather than of an active protagonist.

In view of George's background, it is understandable that he welcomed the opportunity to attend a Northern college. This opportunity presented itself when his father, a graduate of a Northern university, approved of his wish to attend the University of Michigan upon his graduation from high school. Thus, George came to Michigan with the hope of emancipating himself from the servile position that had been imposed upon him by conditions that prevailed both inside and outside the context of his family life. Moreover, he decided to prepare himself to be a lawyer, a profession that, he hoped, would better enable him to participate in the ongoing emancipation of the Negro people.

During his freshman year, George found, much to his surprise and great chagrin, that he could not simply shed the corrosive effects of his background by a sheer act of will. Instead, he discovered that the personality that he had already developed—with all of its inhibitions, defenses, and self-doubts—persisted even under more favorable social conditions. Despite his good intentions, he continued to experience marked difficulty in concentration, severe anxiety under pressure to perform, and an inability to express his feelings appropriately. In short, his basic problems hampered his functioning in most important aspects of his life at the university. Being unable to alter this disturbing state of affairs, George finally came to our mental-hygiene department for help at the beginning of his second semester.

As a result of nearly one year of psychotherapy, George was able to change his pattern of defensive behavior quite significantly. His fear of his father diminished, and he was able to deal with him and with other authority figures in a more straightforward manner. His self-negating tendencies decreased. In general, he began to express more openly his feelings toward others, including the therapist, in whom he had tended, originally, to attribute unconsciously the sort of

punitive attitudes he had learned to expect in white persons.[1]

Therapeutically speaking, things were progressing very satisfactorily until George went home for the Christmas vacation during his sophomore year. In past visits to his home, George had, in accordance with his well-established pattern, studiously avoided contacts with white persons. He had usually restricted himself to the confines of his parents' farm. On his infrequent visits to Negro friends and relatives in the vicinity, George had been careful to avoid the use of public conveyances. On this Christmas vacation, however, George felt considerably less constrained. Thus, not having had time to complete all of his Christmas shopping in Ann Arbor, he decided, shortly upon his arrival, to make some last-minute purchases in his home town.

Buoyed up by his newly developed courage and poise, George drove into town and stopped at the largest department store. After browsing around a bit, he went to the haberdashery section with the intention of buying his father a tie. Just as the clerk began to show George a selection of ties, another customer, a middle-aged white man, walked up to the same counter, brushed George aside with an emotionless "Step away, Nigger," and proceeded to give his order to the clerk. The clerk immediately turned his attention away from George and devoted himself fully to the newcomer. Both the white customer and the clerk acted as if they had ceased to be aware of George's presence.

As this incident unfolded, George was smitten by an onslaught of intense and conflicting impulses. His first impulse was to cringe and he did, indeed, step aside in his old deferential manner. Almost simultaneously, however, he was overwhelmed by a desire to attack, to strike out wildly against the intruder, the clerk, the store, and every one within reach. He was racked with an urge to run amok—to smash and destroy in all directions. Instead, he trembled and perspired without making a single gesture. His mind became flooded with lurid

[1] With Negro patients, two types of transference reactions seem to occur simultaneously. In addition to the classical parent-image transference, Negro patients tend to perceive the white therapist as a representative of the majority group that has oppressed them. Both types of transference reaction must be dealt with psychotherapeutically if genuine progress is to take place. Of course, patients of other minority-group affiliations have similar multiple-transference reactions.

images of the punishment that would be inflicted upon him if he acted upon his hostile feelings. He became afraid again, as scared and cowering as he had ever been prior to psychotherapy.

Then George thought to himself, "I am being a coward. Killing and running wild is certainly not called for by this incident, but the least I can and should do is speak up in protest against such humiliating treatment." George was, in fact, on the verge of speaking when he remembered that he was in the South and that, in the South, "back talk" on the part of a Negro was regarded as a serious matter. He remembered that Negroes had been lynched with less provocation. Thus, he maintained his strangulating silence, stewing in the acid of his suppressed emotions and feeling ashamed, betrayed, and beaten.

When George returned to the university and the therapy situation after this Christmas period, he seemed to have regressed. Many of his old symptoms—his reticence, bemused facial expression, and quiet tension—had reappeared. It took some time to bring forth the impetus of this regression and, when we did so, the implications were clear. In essence, George was telling me: "What is the sense of getting well, if it may cost me my life? While I was protected by neurotic defenses, I was safe. To be sure, I felt invariably empty and the quality of my emotional experiences was blunted, but I was safe. I did not expose myself to situations in which I could be destroyed as a result of a reasonable show of self-respect. If getting well, if reacting like a whole human being is going to incur such drastic penalties, then I'll keep my symptoms. The aim of psychotherapy is noble and it was nice while I could live by it, but the price is too high."

There is no question about the fact that George returned to therapy in an acute state of resistance to change. However, as we have seen, this resistance was provoked by a contact with social reality that placed him in the untenable position of having to choose between adherence to the therapeutic goals he had already adopted and a need to preserve his life. If the dynamic implications of this terrifying brush with reality had not been appreciated by the therapist, he might have clung to a classic, but, in this instance, highly ineffective method of dealing with resistance to change. Thus,

the therapist might have perceived and interpreted George's regressive behavior as an indication of his reluctance to face still unassimilated material of an unconscious nature. Working under this formulation, the therapist probably would not have been able to bring the traumatic incident to light. Moreover, even if the incident had been revealed eventually, the therapist might have been inclined to see in it a smoke screen that George was laying down in order to obscure other and, presumably, more painful material. In any case, by failing to accept unequivocally the actual meaningfulness of the incident, the therapist would have done much to destroy the vital feeling of consensus on the basis of which therapeutic communication and progress is maintained.

As implied in the foregoing, the therapist did, in fact, accept George's behavior as a virtually reflexive response to a situation whose implications presented him with no genuine opportunity to follow the ideal requirements of appropriateness. By doing this, the therapist indicated that he recognized[1] the fact that social reality often sets limits beyond which an individual could not be expected to behave appropriately if such behavior promised to evoke fantastically inappropriate consequences. In acknowledging the validity of George's reaction to a conflicting social situation whose structuring precluded constructive resolution, the therapist helped him to accept himself again.

George gradually renewed his dedication to the general therapeutic goals that he had previously espoused. He grew to realize that the emotional rewards of appropriate behavior were worthy of continued pursuit, in spite of the fact that his minority-group status did not always permit the degree of appropriate responsiveness that is feasible without penalty for majority-group members. Thus, he saw, as he had previously known, that there are many situations in which it would be possible for him to react appropriately without endangering his life. In this connection, George became more open in

[1] Such recognition helped to validate George's awareness of the fact that certain social forces are as real and functionally effective as the forces of nature. However, this recognition of emotionally corrosive aspects of social reality suggested neither approval of nor resignation to the status quo. Instead, by supporting George's continued, but more enlightened adherence to original therapeutic goals, the therapist implied that social conditions that block the fulfillment of these goals are to be deplored.

revealing his feelings to the therapist than he had been prior to the traumatic incident. He reported similar improvement in his interpersonal reactions to other white persons on campus. At the same time, his work in the cause of equal civil-rights for Negroes became more active, constant, and effective.

Admittedly, the incident described in George's case is an extreme and dramatic example of the limitations that social reality may impose upon the ability of patients to fulfill psychotherapeutic goals. Nevertheless, it only high-lights the general problem that confronts Negroes and other minority-group members in our society. Furthermore, these kinds of limitation are not restricted to impingement upon the ideal of appropriateness alone. There are other widely adopted psychotherapeutic objectives that various segments of our patient population find exceedingly difficult to fulfill. For example, the ideal of self-actualization, which is promoted most explicitly by followers of Erich Fromm and Karen Horney, is infinitely more capable of being realized by independently wealthy patients of the upper classes than by impoverished lower-class patients.

When the psychotherapist deals with patients of his own class and caste background, he is likely to have a deeply ingrained appreciation of the emotional implications of that background. This appreciation permits the therapist almost automatically to adapt his therapeutic goals to a social position that places him and his patient under a common set of freedoms and constraints. However, when a therapist is called upon to treat a culturally heterogeneous population of patients, it behooves him to become aware of the conditions of social life that are likely to limit the ability of any subgroup of patients to implement the goals that are inherent in the type of therapy he practices. Such an awareness would permit the therapist to integrate the therapeutically ideal with the socially real. Hence, a broad educational background in the social sciences, together with a thorough understanding of the values subsumed by the "school" of psychotherapy to which he belongs, may help the therapist to avoid technical errors that he might otherwise make.

AN EXPERIMENT IN TRAINING FILM-DISCUSSION LEADERS

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TO meet pressing needs in the promotion of better mental-health throughout the commonwealth, the Division of Community Services of the Pennsylvania Department of Welfare's Bureau of Mental Health developed a film-discussion training course for non-professional leadership. The division's program demanded maximum effective use of audio-visual materials for mental-health education. Best results from the growing library of selected mental-health films depended on presentation with group discussion. The staff was convinced that active audience participation furnished the core of the learning situation. Inherent in this philosophy was a need for discussion leaders. Scarce psychiatric personnel limited professional leadership. Adequate coverage could not be anticipated in the foreseeable future for the increasing number of groups that reached out to gain better understanding of positive mental-health through the medium of films.

Much thought and planning went into attempts to arrive at a satisfactory solution. The answer seemed to lie in training lay people to do the job. The staff and consultants naturally had qualms as to the advisability of using personnel without psychiatrically oriented training to lead discussions about films dealing with human relations and attitudes. However, after consideration it was decided that a sound foundation for experimentation could be established through (1) a carefully selected corps of leaders; (2) a skillfully planned and operated training course; (3) well-defined limits within which

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to operate; and (4) a wise assignment of leaders to groups.

To safeguard the total undertaking, only films that represented a minimum of emotionally charged material were to be selected for presentation by trainees. The focus of discussion would be the material that the film itself presented and the statements embodied within the film; the discussion leader's rôle would be to lead the group to reëxamine these statements in the light of their own experience and perceptions. A planning committee, composed of staff personnel and other professional and lay representatives, designated three of its members to select the films—a psychiatrist and two social workers. This professional technical committee recommended four films acceptable for use during the course and for future use by the leaders: *A Child Went Forth; Children's Emotions; Life With Junior;* and *Shy Guy.*

These films covered a wide chronological range, stirred inquiry about growth and development, but avoided preoccupation with the dynamics of specific situations. Later the following films, centered about parent-child relationships, were absorbed in proportion to the growing competence of the leadership group: *He Acts His Age; Fears of Children; Family Circles;* and *Farewell to Childhood.*

The county that surrounds Harrisburg, the state capital, was selected as the area for the project. Four major considerations governed this decision:

1. The requests for film-discussion leadership were making disproportionate inroads on a staff responsible for state-wide service, since the locality felt a natural freedom to call upon accessible resources.
2. Details could be worked out without necessitating travel for central-office staff.
3. Active county and city P. T. A. organizations indicated readiness for developing a mental-health program with emphasis on audio-visual aids.
4. The locality represented an "average" cross-section, making this demonstration a pilot.

Mixed feelings were roused when members of the division proposed to P.T.A. leaders that a course be instituted to train people within their own ranks who would be prepared to lead discussions springing from audio-visual materials now used by their groups. They liked the idea, but fruitless efforts on their part in the past to develop study groups with competent leadership made them skeptical. It was not an attitude of

"We want no part of it," but an honest "burnt child" reaction. Some were interested enough, however, to want to know more about the proposals; others expected a ready-made plan to rush into full-fledged operation.

From the outset it was made clear that the planning committee, composed of an initial membership of P.T.A. city and county presidents and county program chairmen, would have a central part in the planning of the course.[1] They would work together with additional committee members who would be selected from proposed sponsoring agencies.

Simultaneously, a professional advisory group would be formed to act as consultants. This represented the commissioner of mental health; the superintendent of Harrisburg State Hospital; the director of the child-guidance center; the deputy secretary of welfare; the chief of the division of community services; the Dauphin County Medical Society; the family and children's service director; and the deputy secretary of the department of public assistance.

The tentative suggestions for immediate procedure were:

1. To secure a specialist in human relations to conduct the course.
2. To limit prospective leaders to those in a sphere of non-psychiatric activity.
3. To consider the careful selection of trainees of the training group.
4. To acquaint the group with selected films.

With this much information, the random small representative P.T.A. group wanted to undertake the project. Each leader agreed to take the idea back to his P.T.A. subgroups and to furnish names of those interested. Significant developments followed: inadequate follow-up by the leaders and a consequent dearth of names; enough genuine interest, however, to warrant continuation of the plans; and new awareness on the part of the committee and the division's staff that more time than had been allotted should be given to mapping an approach. It was not without design, therefore, that the plans conceived in March were not complete until September.

In analyzing this preliminary experience, the conviction grew that much of the success of a community training course depends on the amount and quality of shared leadership in the

[1] Schemata delineating effective time sequences for the planning stages are available on request to the authors.

preliminary planning. Out of this growing conception of the undertaking, a more representative, larger planning committee developed. The planning committee enlarged to include broader representation from the division of community services, the P.T.A., health and welfare agencies, and other civic groups.

Specific plans evolved to integrate total community efforts:

1. Preliminary work would continue throughout the summer to pinpoint plans for the fall course.
2. Sponsorship was primarily lodged with the community committee, supported by consultation from a professional advisory committee and the division of community services.
3. The division was assigned leadership in securing the services of a specialist to introduce principles of group-discussion leadership.
4. The course was experimentally set for three sessions, one in each of three consecutive weeks.
5. A preliminary meeting was planned for the purpose of acquainting the executives of organizations with plans, determining interests, helping set goals, clarifying questions, and affording the opportunity of determining how to select representative trainees.

Subcommittees were developed to apportion responsibility for the "get acquainted" meetings—a noon meeting and an evening meeting, to meet the convenience of the various groups concerned. In response to 55 letters of invitation to attend the planning session, directed to key organizations by the subcommittee, 23 representatives met with selected members of the steering committee for the luncheon or dinner. Represented were the women's auxiliary to the county medical society, the Junior League, the Dauphin County Medical Board, the Harrisburg P.T.A., the Rotary Club, the Girls Club of Harrisburg, the Anti-Defamation League, the Pilot Club, the Soroptimist Club, the Girl Scouts, the child guidance center, the Federation of Women's Clubs, the American Women's Volunteer Service, the Harrisburg State Hospital, the Dauphin County Council P.T.A., the American Gold Star Mothers' Club, the Quota Club, the Jewish Community Center, the department of public assistance, and the family and children's service.

The letter that stimulated this interest was as follows:

Dear Executive Director:

At a recent meeting of a committee interested in mental-health films and group discussion around such films, it was suggested that your

organization might wish to be included in a proposed project. This committee, composed of professional and lay people, met because of their concern about the lack of adequate leaders for the discussion which should follow the showing of these films. They came to the unanimous agreement that undoubtedly there are potential leaders in lay groups. It is at this point that we feel that you, as a key representative of your organization, are in a position to be of invaluable assistance.

The project being considered is the setting up of a training course in discussion leadership for a selected group of individuals. We believe that the selection of such a group would have to be made by those who know the eligible individuals within their own organizations.

We are writing to you—and to others who are in similar positions—to ascertain your interest in this project. At this date the plans are to have a meeting for those who wish to join us. At that meeting we will want your help in evaluating this project and in setting up a group leadership course that would be of value to the eligible individuals within your particular organization and to the community as a whole.

We are enclosing a card that will help the steering committee to make definite plans for the meeting. We have had to set an arbitrary date—July 24—but we can give you the choice of attending either a luncheon or an evening meeting. Upon receipt of your card we will notify you as to time and place of meeting.

Hoping that you will be with us, I am

Sincerely yours,

Chairman, Planning Committee,
Film Discussion Leadership Training.

These meetings provided an opportunity to clarify the proposed plan and to give delegates an opportunity to ventilate any feeling that they might have about the course. Stimulation toward careful selection of potential leaders was a natural outcome. A number of heterogeneous ideas were encountered in the group. For example, the films to be reviewed dealt solely with mental illness; generally speaking—and characteristically of this group—people in the community have little understanding of what is meant by mental health; lay people are not equipped to deal with mental-health-content material. The two psychiatrists in the group had given the matter much thought and held that so long as the leaders were sure of their function, and limited their aims to engaging groups of predominately healthy individuals in discussing the film as presented, the project should proceed.

On the other hand, a representative from the county medical society expressed much feeling about the dangers of films' touching the field of human emotions. When it was pointed out that groups have access to films with or without good leadership, he saw some value in training leaders to accelerate

learning through skillful discussion methods. He reserved any endorsement from the medical society until he could submit the plan to his group. His function as delegate was well served since his organization officially wrote to express interest in the plan, but suggested that it be evaluated after a period of actual operation.

Thus erroneous conceptions were brought to the surface and clarified. Sensitive communication, including the recognition of negative aspects, helped create a unified group that could move ahead with the plan.

In order to help the executives to screen the representatives whom they would propose for the course, suggestions about desirable qualifications were assembled. These included: emotional stability, interest in meeting with groups, social sensitivity, adaptability, enthusiasm, and awareness of limitation. Apparently committed to the plan, the group considered such practical aspects as the number of times a year a "trained" leader would be expected to serve, and methods of publicizing the project so that the community would be informed of this roster of trained leaders. General agreement was reached that each person who completed the course should commit himself to at least two meetings during the year.

The decision to release publicity resulted in newspaper headings, such as: "Plan to Aid Mental Health by Films Sponsored Here" and "Mental Health Plan Broadened." News releases described the projected leadership training course as "a program to broaden educational advances in the field of mental health," and as "a plan designed to expand the use of selected mental-health films at group meetings by training laymen as discussion leaders." To acquaint the public with the aim of wide community coöperation, articles carried the list of interested organizations and their selected representatives. Such organizations as the Rotary Club published a squib, described the course as an interesting opportunity to learn group techniques, and added, "Those profit most who serve best."

Following this exploratory meeting, a general session was arranged as a preview of the course. Executives and their representatives were invited to attend. The division of community services had secured a specialist—Dr. Martin

Chwoowsky, Director of the Albert M. Greenfield Center for Human Relations, University of Pennsylvania. He was responsible at this meeting for orienting prospective "students" to the content, techniques, and climate of the subsequent sessions. The thirty-one "previewers" were encouraged to raise questions, and were assured that if they felt the plan was not in accord with their interests after this meeting, they were at liberty to withdraw. Expectations squared more nearly with reality after this testing of readiness for training.

At the first training session, thirty-five men and women met as designated delegates, drawn from a wide variety of backgrounds. No one had had more than casual association with any other member. The original participants included a former nurse and mother of two adolescent children, a recreation worker at a boys' industrial school, a civic-minded club woman, a meteorologist, a leading state-welfare executive, the program chairman for the P.T.A., and an active volunteer for the Anti-Defamation League. The group varied in emotional tone and motivation. Some of them had had wide leadership-discussion experience and wished to improve their technique; others felt extremely inadequate about leading discussions, but felt a drive to promote better mental health. Some openly displayed a lack of understanding of positive mental health, but linked the training course with mental illness. Others merely extended their already firm conviction of the value of parent education or improving mental-health programs through audio-visual material. The rigid and opinionated modified their attitude. The socially sensitive quickened their ability to perceive emotional problems. A mutual acceptance of differences within groups laid a foundation for future community experience. An increasingly pervasive feeling of group unity developed.

Leadership stemmed from the specialist in human-relations training, who determined the nature of the course,[1] encouraged a free atmosphere, and provided opportunity for everybody to contribute. Consultants from the psychiatric professional group served to bolster the content of the films shown to the group. Rôle-playing helped the trainees to project themselves into the feelings of persons who might be part of an antici-

[1] Contents of the entire course may be obtained on request to the authors.

pated audience, and at the same time, to experience as leaders these broad reactions. These anticipatory rehearsals simplified the transference of classroom knowledge and skill to later real-life situations. The leader emphasized here (1) manifest agenda (discussion of the film) and (2) hidden agenda (the process of getting people to participate).

The sessions included presentation by the specialist of the values of group discussion, of keeping it rolling, and of staying on the subject of the film. Leaders were relieved of responsibility for adding something to every remark, for expressing a personal opinion, or for drawing conclusions. On the other hand, leaders were encouraged to summarize the audience's own feelings on the subject and to point up opposing points of view. The group was given the opportunity to view the selected films, to discuss them, and to try out, by actually leading this group in discussion, the skills that they were learning. Much learning occurred during mutual criticism of these practice efforts. There was free discussion about the participants' prospective rôles and a general airing of their limitations as they saw them.

From time to time the group directed some anxiety-filled and many pertinent questions to the specialist. Naturally, all exhibited some fear of meeting groups. For example, one member wanted to know if it would be advisable to have participants stand when contributing to the group discussion; another wanted to know how to handle the over-talkative participant; and another, what to do if the group found fault with or fought against the principles portrayed by the film. What about written questions from the audiences? What to do if the group never "got off the ground"—planted questions? How break up a group that was too large?

In the process of self-elimination, twenty survived the course. Those remaining had a general close sense of membership. This "dropping off" caused little concern. It was felt (1) that those who left were not really interested in becoming leaders or doubted their suitability for such leadership rôles; and (2) that the majority of those remaining had profited from the training and were equipped to "perform" in scheduled film discussion.

At the close of the third and last regularly scheduled session,

the group felt free enough to voice the conviction that they had not been given enough opportunity to practice skills. They expressed a desire for prolonging their experience. Timely response to this feeling of insecurity was of paramount importance. Moreover, this desire seemed motivated by a genuine appreciation of the significance of this commitment.

Group interdependence was abundantly illustrated during the next three successive meetings, which immediately followed the regular sessions. Arrangements were made for the group to continue on a monthly basis, with representatives from the staff of the division of community services to guide them and to provide them with opportunities to test their recently learned skill. These meetings continued successfully for eight months. An average of sixteen members met to participate in film discussion, to share experiences in leading film discussion, and to gain continued support in their new undertaking.

The next step, after completion of the scheduled course, was setting up a roster of leaders and giving careful thought to the assignment of leaders to groups. Responsibility for this task was delegated to members of the staff of the division of community services who had served as chairman of the steering committee. Needless to say, individual differences among members created assignment problems for the chairman. It was important to consider the adaptability of leaders to respective groups, so that effective experience could be afforded both leaders and groups. This was no light task. An appropriate group was not always conveniently available, so that it was inevitable that interest should dwindle among some members. This proved a reality problem that might have been minimized by simultaneously projecting plans for future group meetings while training discussion leaders. It became evident that vigorous exploration of needs for leadership must be uncovered at the same time that training is undertaken.

In general, requests for these leaders have developed in three ways: (1) attention drawn to them by press notice; (2) "satisfied customers"; and (3) further acquainting long-time local film-users with this supplemental service. Illustrations from actual practice of the need for well-considered

assignments pose such problems as an approach to the division saying, "We would like to have Mr. So-and-so lead a discussion for our group. We heard what a good job he did at such-and-such a meeting." Though this was gratifying—from the standpoint both of meeting groups' and leaders' needs—it also created a problem. Were the so-called "good" leaders going to be in such demand that they would be imposed upon? There were times when we said to the enthusiastic program chairman, "We are sure you would enjoy having Mr. So-and-so with you, but if he cannot come, we can provide you with another good leader." Efforts continue to balance leadership experience and at the same time develop a larger body of "satisfied customers."

Review of the assumption of the placement chore by a staff member in this pilot experiment points to the future expediency and wisdom of delegating this responsibility to a qualified member of the non-professional steering committee or to a chairman of the trained leaders.

Any group meeting is planned to make group and leader feel comfortable and confident. To this end, contact between leader and group was effected before the actual meeting. Accordingly, after getting the consent of the leader, a letter of confirmation suggested that the program chairman get in touch directly with the leader to discuss the details of the meeting. It is easier to promote a friendly atmosphere if there is some knowledge of the problems that confront the group and of its previous program experience. In some situations, three or four members of the anticipated audience previewed the film and planned to help their inexperienced groups initiate participation in discussion. Leaders were at liberty to review the films they planned to lead. It was encouraging that they almost invariably wanted to see the film again before leading the discussion, even though they had seen it during the training course.

The mechanics of administration are now smoothly devised for adaptation to the needs of other localities. A card system for keeping a record of assignments was initiated. The cards are arranged according to the month the service is to be given, and after the meeting is held, the card is placed in the inactive file, awaiting further contact with the organization. These

organization cards, together with the individual cards, make possible an evaluation of the use that is being made of the service.

Each leader was provided with an evaluation sheet on which to record his impressions of the group and of his activity in that group. The following routine report high-lights one leader's evaluation during the three months of his service.

SUGGESTIONS FOR LEADER'S EVALUATION OF MEETING

Leader: Mr. X. Film: Answering the Child's Why.

Organization: X X School. No. Attending: 75.

Date: Nov. 19, 1953. Place: X X School, Harrisburg. Time: 7:30 p.m.

Method of leadership (what you did to stimulate discussion):

A brief introduction covering points brought out in the film was given to lay the groundwork for the discussion. Then the group was asked to tell how they might answer the "whys." We referred back to other points in the film from time to time to bring out the reasons for the "why." When to answer the why, how to prepare yourself and the child for soon-to-be-encountered situations so that all can better enjoy them.

How group reacted:

Group was made up of about 60 adults (colored and white), and 15 children (colored and white). It was a very harmonious group with little or no opportunity for cross-fire of discussion except on how to explain and handle the problem of death. One of the children in their school had died the day before. I felt they were with me in the discussion at all times, and were really responsive.

Special problems or questions:

The group was hampered by inadequate space, sitting on tables and standing was common, but their coöperative spirit was high and to be commended. If the group had not been so large and packed into such small space, I think a blackboard-centered summary of discussion could have been used here.

Comments and suggestions

Also in the audience this evening were Mrs. T. of our group and Mrs. R. (city president of P. T. A.). It took me a little by surprise, but apparently they, too, enjoyed the film and the meeting.

Again we had about 12 to 15 persons taking part in the discussion period. The principal and the teachers were at this meeting and they seemed appreciative of the meeting and discussion, although they did not take part in it actively. The teachers and parents at Allison seem very appreciative of each other's efforts, and together they have accomplished much to overcome the handicap of the old-style school building. There does not seem to be any vestige of "high wall" here.

Consideration was given by the committee to having the group chairman furnish a similar written evaluation, but this idea was discarded for what seemed a more adequate plan—a

firsthand contact in which the committee chairman talked with the group chairman to ascertain the group's reaction to the particular meeting. The leaders enthusiastically endorsed this plan, as they felt that it would give them an opportunity to check on their own development. Both forms of evaluation aid the division in meeting the needs of individuals and groups.

In accordance with the leaders' own desires, future steps include a one-day workshop with their total group, the film council, and the steering committee. At this meeting the leaders proposed to develop discussion guides for selected "new" films—*i.e.*, other titles that have been slowly added by the selection committee to the original group of films designated as "within trainees competence to lead." These include: *Children's Emotions, High Wall, Roots of Happiness,* and *The Toymaker.* Many times during the training course members expressed the need for more discussion guides. There are a number of films for which no such aid has been supplied by the producers, and it is from this group that the film-selection committee chose the workshop material.

Similarly, a second step in future planning was in keeping with the leaders' own wishes. At the last of the eight monthly meetings, by group consensus it was requested that a refresher course be scheduled in the fall.

Despite the various methods used to acquaint the community with the service, it seems inevitable that neither newspaper nor grapevine reaches all groups. As a further means of reminding organized groups about the availability of human-relation films and discussion leaders, a letter was sent to each group, enclosing a card to be returned with any indication of current interest. This was addressed to the program chairman.

The primary purpose of the leadership training course was accomplished; it met requests from groups for trained film-discussion leaders. Trainees have met with over 100 discussion groups set up by such organizations as Sunday School classes, P.T.A. meetings, child-study organizations, Y.W.C.A.'s, community centers, civic clubs, medical-society organizations, high-school students, junior leagues, and service clubs. By this more complete film service the gap in

identified unmet needs was bridged. Out of this demonstration workable suggestions for procedures in other sections of the commonwealth emerged.

Dividends in the way of discovering areas of mental-health educational endeavor were uncovered that could be attained only through volunteer activities. For example, after careful preliminary planning, teachers coöperated in a large junior high school with much racial intermingling by organizing a three-day program during which *High Wall* was presented to nine class groups. Teachers and the trained leader joined in stimulating active classroom participation, relating this film, devoted to feeling about "differences," to everyday school situations.

Other secondary gains also became evident. Leaders interpreted film uses to many groups with whom they had natural alliances. One enthusiastic man carried the message, for example, to a conference of ministers from neighboring states and stirred the growth of effective discussion in broader regions. This conviction about the benefits of the audio-visual approach was voiced by a respected churchman who knew at first hand what he was promoting. A trainee becomes one of the best exponents in conveying this to his associate groups.

Vital imaginative suggestions for new consumer audiences sprang from the group leaders' joint thinking. Here was another bonus. Out of their own familiarity, for example, with the point of view of the board of directors, they proposed that *Roots of Happiness* might vividly prove the contention of social workers that emotional strengths exceed material standards of living when it comes to judging values in family life. They felt that an old conflict between lay and professional measures of protective services in many types of family or children's agencies might be resolved with a warm, new comprehension of such mental-health elements in growing children as this film depicts. Here the professional and community leader could base the discussion on a reality situation and avoid remote abstractions about factors conducive to emotional good health.

Secondary gains were also discernible in the personal growth and development of leaders. This by-product was dramatically demonstrated by a leader who was initially

skeptical and naïve. Several months later, when a new film produced by the division was being evaluated, prolonged discussion arose among professionals about its implications for unselected lay groups. Mrs. H. rose, with a confidence born of a background of genuine knowledge of general audience reaction, and said that she saw no reason why this film could not be universally used. She represented a new kind of *expertise,* not possessed by "professionals," who are too often isolated from such group experiences with the public. Freed from all the complicated entanglements of technicalities that were bogging down the confused professionals, she penetrated directly to the essence of the film's manifest meaning and stated, "This film simply says to me—feelings are facts, too."

To summarize:

1. The training experiment in film-discussion leadership served the purpose of providing discussion leaders, trained to help groups gain a better understanding of positive mental health through the medium of films. Many secondary gains were also recognized during the pilot demonstration described in the development of this demonstration.

2. Over-all objectives were best met by shared responsibility with broad representative community groups in extended preplanning.

3. Essential to the conduct of the total plan is the clear setting of limits; the leadership-training course plans to prepare leaders for discussion only after the showing of selected mental-health films.

4. The careful screening of leaders is based on the premise that the group will be limited to lay leaders and thus exclude active professional personnel.

5. Close alliance is necessary with an advisory professional group who are prepared to act as consultants in fashioning the total program to meet individual community needs and interests.

6. No program should be superimposed, but opportunity must be provided to ventilate negative reactions to the project, to examine goals, and to test readiness for participation and develop realistic expectations.

7. In the actual conduct of the course it became clear that the arbitrary planning of three sessions did not offer sufficient opportunity to develop the learner rôle.

8. Concentration of additional sessions are essential, to consolidate gains and to permit the practice of leadership skill and greater familiarity with film content.

9. Continued subsequent meetings of leadership trainees and professional consultants is a basic method for evaluating experiences, increasing satisfactions through mutual support, and contributing to individual growth and competence, as well as providing timely help at critical episodes.

10. The development of a roster for assignment of discussion leaders indicates the need for careful administration of mechanics, for interpersonal relations between assigned leaders and groups.

11. Stimulating interest among community groups should be carried out simultaneously with the training of leaders. This enables the best use of trainee talent at the height of enthusiasm immediately after the training.

12. Continuing publicity, individual reminders, and available service to all community groups, besides developing "the satisfied customer," through proper matching of leader and group, underlies the maintenance of smooth conduct of the film-discussion plan.

THE EMOTIONAL PROBLEMS OF THE STEPCHILD

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THE stepchild has rather special problems; he has lost a parent and he has gained another parent—a stepmother or a stepfather. He finds it necessary to adjust to new conditions. How well he will adjust is dependent upon several factors, and among the most important of these is age. Ordinarily an infant will achieve a satisfying relationship more readily than an adolescent. When the child is young, pliable, and sufficiently dependent to feel the need of some one to caress and fondle him and help him with his troubles, he will adjust quite readily to his stepmother.

The younger a child is, the more helpless he is, and the more he craves affection and mothering. He cannot live happily without such attention; it is a necessary part of his growth and development. If he receives the affection he craves, he is willing to accept a substitute parent with fewer reservations than an older child. An older child has too many memories, and if they are pleasant ones of a mother or father who has departed, he is still attached to them, and he cannot too easily forsake them. He will be more apt to consider the stepparent as an unwelcome intruder into the family circle. He will be resentful, distrustful, and suspicious.

The stepparent's lot is not a happy one. Very often a stepmother finds a child of five or six rather difficult to manage. If he has been pampered by an overindulgent aunt or grandmother, he may have developed habits that can be changed only with great difficulty. Here youthfulness will not always assure a successful adjustment to a stepparent. There are quite a few other factors that enter into the situation. These are previous upbringing and physical, mental, and emotional health.

As the child grows older, the difficulties of adjusting to a new situation increase. This is particularly true when a stepparent enters the picture. The child has already made

adjustments to his own parent and has arrived at a more or less satisfactory situation; he is set in his ways and he has succeeded in adjusting himself to his family situation. With the arrival of a stepparent, he has to rearrange his ways of living to suit this new parent, and the older the child is, the more difficult it is for him to do this.

When children are striving to attain status of individuality and independence, it is particularly difficult to accept the added burden of the new family tie. A stepmother may earnestly desire to make a good home for her stepchildren, but, try as she may, she will find that in many ways her ideas and standards will differ from those to which the children have become accustomed. Rarely has she had anything to do with the upbringing and training of the children, and she has not had an opportunity to become familiar with their habits, ways of thinking, personalities, and physical peculiarities. Had she been with the children from the time they were born, they could have grown up together gradually and things would certainly be easier.

In addition, some stepmothers have had little experience in dealing with children. Even the most carefully thought-out plans may become disrupted when one of them acquires an adolescent stepchild, particularly if he has been overprotected and overindulged by some relative. She will have a very difficult time trying to undo the damage that has already been done. No matter how skillful and patient she may be, she is already under a disadvantage because she is a stepmother and as such all her actions are suspect. Every move she makes is regarded with suspicion by the stepchild, and the situation becomes very difficult.

It is not at all surprising that a child reveres and idealizes his departed parent, for even though there are, without the least doubt, many good and worthy stepparents, he feels rather dubious about the chance of having a second home as good as the first. The first of everything seems better and more desirable. If the mother has died and there are several children, a caretaker is undoubtedly required. A new factor has now entered into the picture. The father has a more restricted range of choice than before the first marriage. There are many women who will not want to take care of and

bring up some other woman's children. The father may make a good choice or a bad one. No one actually knows until the stepmother has entered into the family circle and begins to function as a substitute parent. She may have the intelligence and personality to be a good stepmother, or she may not. In some cases, there may be a poor beginning with subsequent improvement of the situation.

One of the most pressing problems a stepparent, especially a stepmother, must face is that of finding satisfactory rôles for her stepchildren. If the children are no longer infants or very young, they have become accustomed to certain rôles, and these cannot be disturbed with impunity. If a stepmother comes into a home and, in her desire to institute a coöperative household, assigns the task of washing dishes to an overgrown boy, athletically inclined, who regards such a task as a "sissy" one, she will get into difficulties. If she is wise and understanding, she will study the personalities of her stepchildren, their desires and inclinations, and assign to each a task that he or she would like to do. A little common sense will go a long way in a situation of this kind.

The child's emotions are of the greatest importance in the family situation. Insecurity very often manifests itself in rivalry for affection. When a child feels uncertain and insecure, he may make a strong effort to get his full share, and quite often more, of affection. He will endeavor to keep for himself as much as possible the attention of his real parent and resent bitterly sharing any of it with one who is a newcomer into the family circle. Quite often a stepchild feels that, instead of having got a mother for him, his father has got a wife with whom the child must share his father. Often, when there is a very close relationship between the child and the real parent, the child resents the coming of a stepparent and uses every endeavor to crowd out the newcomer.

When a child feels that he is being crowded out of the affection of the real parent, by the stepmother, it makes little difference how good she is; he will turn against her. In this instance, jealousy is a very important factor. The child is jealous of his father's affection and does not want to share

it with any one. Jealousy is also manifested when the father begins to shows affection for the stepmother with apparent disregard for the child. Jealousy may then become mingled first with envy and later with resentment.

There may be times when a child is rejected by the stepparent and then gradually is rejected by the real parent. In order to hold the new mate, the real parent will pay increasing attention to the stepparent and thus crowd the child out. Affection is withdrawn from the child and concentrated exclusively on the stepparent. This will intensify any feelings of jealousy and envy, which may have existed only in slight degree before.

Quite a few children have complained that the stepparent becomes the dominant and central person in the home and exerts undue influence on the real parent. When this is the case, the child is almost entirely left out of the family picture and he comes to feel that he is unwanted.

The status of a stepchild is never a very happy one at the outset. If a parent in a well-integrated family dies, the child loses a companion, a sympathetic friend, a guide, and a counselor, to whom he has been closely attached, and this quite often has a disastrous effect on him. The orderly pattern of life in the home is often changed with rather unnerving abruptness, and the child is left adrift emotionally. He has the uncomfortable feeling that he no longer has a haven of security to which he may return with confidence after buffetings in the outside would.

The stepchild is often plagued with feelings of insecurity because of his situation. A feeling of insecurity may come about in one of several ways. When a child considers that he is treated differently from others, he feels insecure. He does not know how to respond to an unpatterned situation, nor does he know how to adjust to it. When the stepparent treats the child differently from the way he has been treated by his real parent, he becomes bewildered. He feels that he is being singled out for special treatment not to his liking or understanding. He feels somewhat stigmatized, somewhat different. This leads to insecurity, intermingled with feelings of inferiority and jealousy.

Sibling rivalry, particularly when favoritism is shown to

a brother or sister, very often leads to feelings of insecurity and frustration. Quite often this may be serious in an unbroken home, but in a home that has a stepparent, it may become a very significant problem. When a child is born to the second union, it demands the greater portion of the mother's affection and attention, and the father also gives some of his time to the new arrival. Because this new child has two real parents while the stepchild in the family has only one, the baby usually has certain advantages that tend to make the older child feel less important and for that reason less secure.

Quite often children apologize for the difference and even tell lies to conceal the fact that they have a stepparent. Because of the traditional attitude toward stepparents, and particularly toward the stepmother, the stepchild often develops a sense of inferiority because he, unlike other children, has a substitute parent. Because of this, many children who acquire stepparents in infancy are not told about it. However, when they learn the true facts later on, they experience some emotional shock and disappointment.

The stepchild has special problems of his own to face and solve. He cannot do this alone, without help from the adults in his family. But quite often just a little common sense and ordinary consideration will go a long way toward making his life a happier one.

THE THERAPEUTIC SOCIAL CLUB

AN IMPORTANT MEASURE OF SOCIAL REHABILITATION IN THE TREATMENT OF PSYCHIATRIC CASES

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IN recent years the number of patients who seek psychiatric treatment has increased substantially. In consequence, psychiatrists are faced with the problem of insufficient time to cope adequately with all their patients, especially from the psychotherapeutic viewpoint. Therefore, any adjuvant therapeutic measure calculated to reduce the time of standard psychotherapeutic methods, and capable of dealing with large numbers of patients simultaneously, warrants attention. This article concerns just such a measure.

It is only during the present century that any substantial progress has been made in comprehension of the ætiology of psychogenic illness. Since the epoch-making work of Freud in the early years of the century, considerable advances have been made in the field of psychopathology and increasingly more attention has been paid to social psychiatry and interpersonal relationships.

Man is a gregarious animal, and many psychiatrists have been at pains to demonstrate the existence either of a herd instinct[1] or—if they are not prepared to acknowledge the existence of an actual instinct—of an inherent gregarious or social urge throughout the human species. There are few modern psychiatrists who deny the importance of this aspect of man's mentality and personality, and the development of sociology and social psychiatry confirms the extent to which this concept has extended.

[1] See *Introduction to Social Psychology;* by William MacDongall. Revised edition. (Boston: John W. Luce and Company, 1926.) See also *Instincts of the Herd in Peace and War,* by W. Trotter. Revised edition. (New York: The Macmillan Company, 1926.)

Amongst the founders of modern psychopathology, it was Alfred Adler in particular who stressed the significance of man's social urges and needs. He coined a word in German, "*Gemeinschaftfullen,*" which is difficult to translate into English, but which, broadly speaking, implies a sense of "belonging" to a group or a community. Perhaps the nearest approach to an adequate translation is the English word "fellowship." Individual man, Adler contended, can never afford to isolate himself from his fellows without disastrous effects on his mental well-being.

There is nothing more tragic than the human individual who feels lonely, isolated, and at variance with his fellows. The number of such persons in our midst is legion. Despite the conquest of space by modern means of transport and communication, loneliness is probably more prevalent in the world than it has ever been. The barrier of distance has been replaced by that of emotional tension and conflict, as the main source of isolation from one's fellows, and where population is most dense, lonely persons are likely to be most prevalent. I have no doubt that the most important specific factors in the causation of loneliness are mental maladjustment and illness.

E. B. Strauss writes[1]: "It is an undoubted fact that faulty social attitudes play an important part in the psychopathology of many mental and emotional disorders, and—what is not sufficiently well recognized—a mentally sick person's relations with his fellowmen are invariably defective, no matter what the ætiology of his illness may be." In every form of chronic mental illness the course of events follows the same pattern of increasing egocentricity and introversion and diminishing sociability and fellowship.

The general gist of this trend has been recognized for many years by numerous doctors and psychiatrists, but until recently only inadequate steps were taken to try to counteract it. Many misconceptions regarding this matter still exist, the two main ones being (1) the belief that the patient's special defection is entirely secondary to his fundamental psychopathological complexes and, therefore, will respond

[1] In his Introduction to *Therapeutic Social Clubs*, edited by Joshua Bierer. London: N. K. Lewis and Company, 1948.

only to psychoanalysis or to some other form of deep psychotherapy; and (2) the idea that patients suffering from mental illnesses are so incapacitated and irresponsible socially that they are incapable of managing their own social activities and, therefore, must have ready-made entertainments and social recreations provided for them. These misconceptions are the result of failing to comprehend the relevant factors that affect the patients' social feelings and activities.

One has only to be aware of the symptoms of the various mental illnesses to realize their significance in this respect. Those patients who recover rapidly will probably soon be able to resume ordinary social functions, but those who suffer from more prolonged or chronic illness frequently find it absolutely impossible to participate in ordinary social functions and activities. Probably the highest common factor amongst such cases is an "inferiority complex." Because the patient feels inferior—no matter what the cause—he feels different from his fellows and progressively more awkward and unhappy in their company, so that he is impelled to shun all social activities. The fact that he has to do this makes him feel still more inferior and so a vicious circle is set up.

Despite this, his desires for sociability persist and his potentialities for affability and friendliness and his capabilities for self-expression are latent. It is the object of therapeutic social clubs to provide an environment in which these potentialities and capabilities may blossom forth—often very gradually—once more. The value of such clubs has not yet received the recognition it deserves, and many patients are still deprived of the opportunity of such assistance because of the lack of appreciation of the important rôle they can play as an adjuvant to other forms of therapy.

It is not my purpose here to discuss the organization of such clubs in any detail. Suffice it to say that the principle of such a club is to give patients a chance to take part in social activities in a club whose members have themselves suffered from similar illnesses and disabilities (or who are relatives of such persons); a club where their difficulties will be understood by the other members and no pressure will be placed on them to join in activities when they feel averse to doing so; a club where they will have the opportunity to elect their

own committee, make suggestions for improvements, and finally take office on the committee themselves; and finally a club where the presence of a psychiatrist and social therapist offers help and reassurance to those requiring it. The importance of each of these attributes has been discussed elsewhere.[1]

The vindication of such clubs is to be found in the results obtained. There is nothing so dear to the minds of the modern bureaucrat as statistics, and this applies to the medical and psychiatric bureaucrat as well as to others. However, there are so many variable factors appertaining to each patient who attends a therapeutic social club that, in my opinion, statistics are likely to be fallacious and even misleading one way or the other, and I do not propose to quote any. Instead, in an attempt to demonstrate the results that may be expected, I propose to describe some of my own observations, to quote actual opinions of certain patients, and to epitomise three case histories.

Admittedly this method is subjective, non-scientific, and open to all the usual objections raised against such procedures, but, nevertheless, I fear that it is the only one available in the circumstances prevailing in such organizations. One must really witness the progress of patients in a club one's self to appreciate the results achieved.

Outpatient Clubs.—For six years I have supervised a therapeutic club for outpatients. Meetings are held once a week from 7:30 p.m. to 10 p.m. Patients of many types have been members of this club—psychoneurotics, recovered psychotics (even some with persisting symptoms), and occasional epileptics. They have all been National Health patients, but their social and economic status has varied considerably from one patient to another.

Spontaneously and without any direct questioning, many such patients have expressed to me the feelings of social ostracism they felt before joining the therapeutic social club; their reluctance to join it; and the agonies of self-consciousness, shyness, and awkwardness they experienced at their first attendance, despite the tactful kindness and help they received.

[1] See "Formation and Organization of Therapeutic Social Clubs," by Donald Blair, in *Therapeutic Social Clubs* (*vide ante*); also in *Hospital and Social Service Journal*, Vol. 60, pp. 463–64, April, 1950. See also "Multidimensional Treatment of Mental Illness," by Donald Blair. *The Medical Press*, Vol. 221, pp. 504–07, May, 1949.

Gradually, and often with much tribulation, they have become progressively more friendly and more sociable, and gained more self-respect and self-confidence, until finally they have been able to participate in the club activities with enjoyment and good-fellowship and many of them have eventually achieved the responsibility of office on the club committee.

One patient related to me how he used to come as far as the doors of the hall where the club was held and then, usually at the last moment, would panic and rush home again.

Another would stay for only a few minutes during her early attendances. She required very tactful handling and one had to avoid direct exhortation to longer visits or any semblance of reproach for her rapid departures. She is now an enthusiatic, happy member of the club and frequently brings her husband as a guest.

A third who was receiving psychotherapy was referred to the club by her psychotherapist, but in her own words, did not come for another eighteen months, "as I dreaded making contacts with people."

I could quote many other examples to illustrate the really distressing and intense degree of social debility these patients experience, and my own observation of their behavior in the club has eloquently amplified any such personal revelations as those above.

I have observed that the pattern of social progress pursued in such a club is, broadly speaking, common to nearly every case and involves the following stages:

1. *Initiation.* During this stage the patient evolves from the agonizing self-consciousness, awkwardness, apprehensiveness, and lack of self-confidence that make it a great effort to attend at all, to the state when he comes to the club willingly and comparatively free from the above feelings.

2. *Passive membership.* During this stage the patient gradually makes the acquaintance of more members and may sometimes be induced to participate in friendly conversations and to join in games.

3. *Active membership.* The patient joins in club activities freely and with real enjoyment, affability, and friendship, expressing himself in discussions and helping in social functions.

4. *Responsible membership.* He or she becomes a member of the club committee, and may assume office in due course and possibly become chairman.

5. *Departure* from the club because the patient has recovered or improved sufficiently to join an ordinary social club.

All patients grade up to stage 3 if they consistently attend the club. Many achieve stage 5, but some, including especially recurrent psychotics, remain permanent members and attend regularly.

For one reason or another patients have from time to time written me and not infrequently they have spontaneously discussed the effect the club has had on them. The following are a few self-explanatory quotations from such letters:

> "I have never managed to make friends with any one, or to go out anywhere, but the club is such a great help that I look forward to every Wednesday night."

> "I believe that this club is an asset to all members. People at one time or another find themselves lonely and miserable and in this club they regain friendship and enjoyment. It is to me like a tonic and when I come away, I feel that I have had some relief from pain and suffering."

> "It was at the club that I first began to feel the effects of relaxation, companionship, and the wonderful feeling of belonging somewhere—and being wanted. For so long I had felt myself isolated from people that gradually I began to lose any desire to have friends or work or think about myself in any other but a selfish way. The club changed all that. First I began to feel relaxed—not tensed up all the time, waiting for something unfortunate to happen. Then there was the gradual move into mixing with others, and finally the time came when I began to feel that keen desire, not just to live for myself alone, but to help others and forget myself."

Each of the above quotations is from a different patient.

Apart from helping to restore to patients their self-respect, self-confidence, and sociability, the club milieu has fostered in many patients artistic abilities never previously realized (singing, acting, dancing, and so on) and in others an ability to take part in discussions and debates, an attribute that they had always been too self-conscious to use.

Several members who had joined the club with a severe degree of psychiatric disability passed through all the stages of progress described above and eventually married happily. So far they have all remained well for periods of up to several years.

The beneficial effects that a therapeutic social club may

have for some patients are indicated in the three case histories that follow.

No. 1.—Mr. H., aged twenty-eight, was referred to the club from a teaching-hospital clinic. He had suffered from a chronic severe anxiety state for many years. He has one brother, three years older, and one sister, one year older, than he. The brother had always ignored him, taunted him, and refused to allow him to take part in any games with his friends. He had developed inferiority feelings, and resorted to the company of his sister, although still desperately anxious for the friendship and love of his brother. He became very shy and awkward in company, though he fought hard against these feelings.

His school record was fair. He became an N.C.O. in the army during the war, but never mixed well with other N.C.O.'s. After the war, his symptoms became much worse. He was always self-conscious, and became solitary and unsociable. To mix with others was agony. Depressed, despondent, miserable, he lost his self-respect.

In the club Mr. H. found great difficulty in establishing any friendly contacts for a long time. There was a very gradual initial improvement, but over the course of two years improvement accelerated. He was eventually elected first as a member and then as an officer of the committee. By now he was taking part in all club activities with zest and pleasure. He had become able to participate in ordinary social activities and to join a dancing club. He finally achieved complete social rehabilitation.

Mr. H., attended the club for four years and during this time, had no psychotherapy or other psychiatric treatment. His anxiety state improved simultaneously with his social rehabilitation. A year ago he had a short, severe relapse which responded rapidly to psychotherapy. He has now recovered completely from his neurosis.

No. 2.—Miss S., aged thirty-one, first attended the psychiatric clinic in 1943, with complaints of dyspnœa that had been occurring sporadically for six years. There was no organic abnormality; the symptoms were due to chronic anxiety hysteria. She complained of worry about the blitz, about financial worries, and about her evacuated son.

She had been brought up in a poor, but religious family, and lived with her mother. She had had an illegitimate child, and was scorned and patronized by her family (so she said). She had ideas of guilt, unworthiness, and reference. But she managed to carry on at her work with periods off for "rheumatism," fainting attacks, and so on. She had no social activities or contacts, and was anxious, agitated, awkward, and apprehensive in strange company. She had no friends.

Miss S., came under my care for the first time in 1946. In view of her age, her rather low intelligence, and her chronic illness, I considered that ordinary methods of psychotherapy were not suitable and decided that social rehabilitation was the primary aim and I referred her to my therapeutic social club. She was allowed to bring her son with her.

The stages of "initiation" and "passive membership" were prolonged and improvement was very gradual, but she attended regularly and eventually attained the stage of active membership. There was no other treatment except short routine monthly visits to me at an outpatients' clinic, for supportive interviews and sedatives.

Despite the long duration of this patient's psychoneurosis, she was

very gradually socially rehabilitated and her general psychiatric condition improved concomitantly. She has now regained her self-respect, is not excessively sensitive to the opinions of others, and is quite self-assertive and able to fend for herself.

Although her son has recently developed serious physical illness, she is now able to face the situation in a realistic, rational fashion, and while deeply concerned, is not hysterical.

She attended the club for five years, but has recently ceased to do so. She is getting married (a situation that she personally is amazed to have achieved). The change in this woman has been really remarkable and in my opinion is due almost entirely to the social rehabilitation which, with patience and persistence, we gradually managed to effect.

No. 3.—Miss Y., a young woman of twenty-nine, was referred to me suffering from anxiety hysteria. For two years she had suffered from palpitations, dyspnœa, attacks of "fear and tremors" for no apparent reason, lack of concentration, impoverishment of memory, and bouts of depression and tears.

Miss Y. was the youngest of five children. There was a gap of seven years between the third and the fourth child, and then another small gap between that child (a sister) and Miss Y. This sister and Miss Y. had "never grown up" in the eyes of the parents and elder siblings—had always been patronized and treated like children rather than adolescents and adults. The family was financially well off and Miss Y. had stayed at home and looked after her parents, now both dead. She had always wanted to earn her own livelihood, but her older brother and sisters told her that she would never be able to do this.

When I saw her first, she was shy, timorous, supersensitive, very lacking in self-confidence, maudlin, sentimental, and hysterical. Although by nature friendly, congenial, and well-disposed toward others, her illness had led to inferiority feelings, self-consciousness, and inability to make friends, or to take part in any social functions.

This case was first treated by group psychotherapy, combined with periodic individual interviews. Miss Y.'s progress initially was slow. She exhibited emotional ambivalence and resistance and sometimes she did not attend for three or four weeks. In due course she improved sufficiently to be introduced to the therapeutic social club. I observed her carefully and she obviously experienced much emotional embarrassment, discomfort, and difficulty in associating with members of the club. During her early visits, she spent long periods sitting by herself, merely observing the activities of others. However, her progress gradually accelerated through all the stages described above.

Eventually she became socially rehabilitated and joined outside social clubs. She recovered from her neurosis and has recently married and settled down happily.

In my opinion there is no doubt that, in this case, the situational social rehabilitation achieved in the therapeutic social club was an extremely valuable adjuvant to group and individual psychotherapy and definitely diminished the duration of psychotherapy required to achieve recovery.

Inpatient Clubs.—Such clubs are of somewhat different caliber from outpatient clubs, and of course are exclusive to mental hospitals, or mental-deficiency colonies.

They are of two types: (1) those whose membership is confined to patients of comparatively recent admission and with good prognosis; and (2) those dealing with chronic patients who will require permanent care, supervision, and asylum. The principles of organization are broadly similar to those already described, but in the second type, it is obviously necessary for one or two members of the hospital nursing staff to render tactful assistance and supervision.

I inaugurated clubs of each of these types at St. Bernard's Hospital five years ago, and they have both thrived and proved of great value. If one has any doubts regarding the basic inherent desire and need for social fellowship in all of us, experience in clubs of this type will dispel it. It has been an interesting experience to me to see the enjoyment and enthusiasm that even chronic patients experience in club activities.

Very recently further clubs have been started for deteriorated patients who require closed wards. Group training, plus social-club activities, have had amazing effects on many of them and it is certainly a revelation to watch patients previously considered irretrievably deteriorated, and lost to the world of reality, enjoying social activities.

It should be appreciated that whereas such inpatient clubs do not necessarily require the constant attendance of a psychiatrist, the patients appreciate any interest shown by a "doctor," and it adds to their pride in their club if hospital psychiatrists visit it, even for a few minutes, now and then.

In conclusion, I would like to emphasize that the therapeutic value of such clubs—both for outpatients and for inpatients—is in my opinion now established beyond all doubt, and I would make a plea for a more general appreciation of the great help such clubs can confer on their members. Granted this appreciation, patients at present deprived of such club amenities would in the future have the opportunity to benefit from them.

A CRITICAL EVALUATION OF THE THERAPEUTIC USE OF A CLUB IN A SCHOOL-BASED MENTAL-HYGIENE PROGRAM

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SOME thirty years have elapsed since Freud posited principles and charted the future course of investigations into group psychology[1] which led ultimately to the field known to-day as group therapy. Pioneer work by Wender[2] and Schilder[3] and later by Slavson[4] and Redl[5] contributed to bringing about a tremendous growth of interest in the area. As a result of this rapid expansion, the generally accepted definition of group therapy as "the simultaneous treatment of two or more individuals"[6] to-day seems loosely conceived. Psychiatric and educational literature abounds with such terms as "group interaction," "group dynamics," "psychology of group life," and so forth, and a recent survey revealed the

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1 See *Group Psychology and the Analysis of the Ego*, by S. Freud. (International Psychoanalytic Library No. 6.) New York: Boni and Liveright, 1922.

2 See "Dynamics of Group Psychotherapy and Its Applications," by L. Wender. *Journal of Nervous and Mental Diseases*, Vol. 84, pp. 54–60, July, 1936.

3 See "The Analysis of Ideologies as a Psychotherapeutic Method, Especially in Group Treatment," by P. Schilder. *American Journal of Psychiatry*, Vol. 93, pp. 601–17, November, 1936.

4 See *An Introduction to Group Therapy*, by S. R. Slavson. New York: The Commonwealth Fund, 1943.

5 See "The Psychology of Gang Formation and the Treatment of Juvenile Delinquents," by Fritz Redl in *Psychoanalytic Study of the Child*, Vol. 1. New York: International Universities Press, 1945.

6 See "Group Therapy as a Specialized Psychotherapeutic Technique," by H. Spotnitz, in *Specialized Techniques in Psychotherapy*. Edited by G. Bychowski and J. L. Despert. New York: Basic Books, 1952.

salient fact that in such a contemporary periodical as the *American Journal of Orthopsychiatry,* almost one of each five articles dealt with some aspect of group therapy.

The general growth of the mental-hygiene movement over the last twenty years, coupled with the lack of adequately trained therapists, gave impetus to attempts to meet the needs of individuals by placing them in groups to be treated by a single therapist. Abuses naturally crept in, partly as a result of the loose conceptual framework and partially because the individual who hoped to accomplish the treatment did not have the new techniques which call for specific training. Recent evaluations have exploded two widely held misconceptions: (1) that techniques borrowed from individual therapy can be transferred *in toto* to the group process; and (2) that group therapy is cheaper and shorter than individual therapy.[1]

It is quite natural that educators, faced with the necessity of working largely with groups, rather than with single individuals, have viewed the recent growth of group therapy with interest. Current trends in teacher education often emphasize the teacher's rôle as a leader of groups, and not infrequently as a "group therapist." More practically, however, a combination of compulsory school laws, which bring many acutely disturbed children to school, and the pronounced shortage of trained treatment personnel within the school organization, have caused many school administrators to experiment with programs involving a single therapist working with a group of children in a treatment setting.

Such conditions obtained in the public schools of Rochester, Michigan, some five years ago, and the mental-hygiene staff, consisting of a standard clinical team, decided to experiment with the therapeutic use of a club consisting of seven preadolescent boys. Expectations were realistic in that all who participated in the project recognized that its organization was one of expedience necessitated by heavy individual case loads. It was felt, nevertheless, that the experience would serve somewhat in the nature of a pilot study designed to shed light on the therapeutic use of clubs within the school environment.

[1] See "New Ways of Ego Support in Residential Treatment of Disturbed Children," by Fritz Redl. *Bulletin of the Menninger Clinic,* Vol. 13, pp. 60–66, March, 1945.

Close examination of the possibilities led us to hope that the club would also aid us in the following three ways:

1. In diagnosis and prognosis of individual cases. Since we were literally overwhelmed with referred cases, we were forced to make diagnostic and prognostic judgments upon the basis of the reference statement or of a single interview. Frequently we found that there was a certain disparity between our impression of the severity of the child's condition and the teacher's report of his behavior.

2. In offering help to the teacher through our own discovery of what control techniques were most effective in handling the acting-out child. We were often besieged with requests for help from teachers relative to children with whom we had had little contact. The teachers wanted suggestions regarding the classroom handling of such children. We recognized the distinctions between impressions based upon a face-to-face contact with an individual child and those stemming from group-related exposures.

3. In determining whether the instructional staff could carry on with similar groups on their own. It was obvious that the clinical team could never handle all or even most of the personality problems in the school system. We hoped that perhaps we might train the staff to perform in an adjunct capacity.

We propose here to describe the composition and character of the club, as well as to enumerate the problems that each child brought with him. The group tone and flavor will be given, along with some attempt to evaluate the impact of the leader upon the group. It is our impression that the problems of the youngsters in the group are typical of those of referred children in any school system. Our original impression was that they were not the most disturbed children in our clientele.

The membership of the club comprised seven boys between ten and twelve years of age. Their chronological homegeneity was a principal factor in grouping. Admittedly, the heavy case load was an impetus toward considering the group milieu as a therapeutic aid. The reasons for selecting these particular boys, however, were varied; for example in the case

of one boy, we hoped to secure a diagnostic picture that would aid us in planning an individual-treatment program.

Selection did not follow the lines laid down by Redl; the character and number of cases referred to us did not permit optimum or even good grouping. As noted above, the project was not initiated with any naïve illusion regarding the use of groups to replace individual therapy. Instead, the project was a deliberate attempt to observe and understand how these referred children functioned in groups. Our reasoning told us that it was important to see them in a group as their teachers did. We hoped, thereby, to increase our understanding of the teacher's technical difficulties. To phrase it in yet another way, our hope was to observe the child in a freer, more mobile group, in order to learn in what way his group techniques either failed or were inappropriate. On the other hand, we were eager to learn the effect of the group upon the child.

The leader had had good experience with groups of disturbed children, and had, in addition, been associated with Redl in group-therapy projects for several years. He had a background in individual therapy as well as experience with groups of normal children.

Brief sketches of the seven boys who comprised the group follow:

Jim, who was ten years old, lived with his divorced mother. His father, since remarried, had left home when Jim was five. The boy presented an unhappy, bitter appearance. His mother was likewise sour, unhappy, and filled with hate. There was no doubt in Jim's mind that he was unwanted, and he did everything throughout his school career to turn this feeling into reality. He was without friends and trusted no one. The teacher's statement in referring him described Jim as a clown, an inordinate attention-seeker, and an academic failure.

James, also ten years old, lived with his father and his stepmother. His teacher regarded James as unusually feminine. He presented no scholastic problems. A constant butt of boys' pranks, he clung to teachers and to girls.

Wes, an eleven-year-old, a gnomelike figure, had been referred for classroom mischief by a strict, compulsive teacher. Little else was known about him. Although it was

felt that the teacher's rigid control had precipitated his unruly behavior, he was placed in the club for observation.

Jerry, twelve years of age, was outwardly a large, cheerful youngster. He had been referred originally for his poor scholastic work and uncontrolled behavior. He was the oldest of eight children and an only boy. Little control existed in the home, and the overworked, harassed mother seemed lost in face of the demands of the large family. Earlier experience in individual therapy had clearly demonstrated that he was a somewhat delinquent, but realistic boy.

Larry, another ten-year-old, had originally been referred after several accidental soilings. Our early exploration in this case had uncovered a disturbed, moralistic mother who was pathologically involved in his toilet habits. Scholastically, his adjustment was good and he was quiet and shy.

Dick, also ten years of age, had been referred for open classroom fighting with a younger brother, along with poor school work and some stealing. His family were in particularly bad economic straits. Corporal punishment had been used to excess, and he appeared sullen and belligerent.

Bruce, eleven years old, had been referred by his mother. No problem had been noticed in school. The mother was quite involved in youth activities and was certain that her son must be suffering from the effects of her poor marital relationship. He presented an affable, friendly appearance.

It is important to note that four of the boys had difficulties controlwise, and by virtue of this fact, would dominate the group. The youngsters initially tested the leader and found that he did not react as did their teachers. The group life became a stage upon which each child unfolded his own pathology. In this fashion a somewhat more accurate picture of the children resulted.

For example, Dick demonstrated the greatest control difficulty. He was completely indifferent to the feelings of others and acted on an impulse as soon as it was felt. His relationship with the other boys had no depth or reciprocity; it was as if a relationship provided him with only a temporary vehicle. Once the act was completed, Dick had no need to continue the relationship any longer.

Since there was no room in the school that insured complete

privacy, it was as if the children were performing for an audience. The openness of the meeting room contributed, unfortunately, to an air of seductiveness, stimulation, and surreptitiousness. The acting-out youngsters became inclined to move out of the meeting room. As a result, new quarters were secured in the basement of a building some distance from the school. A typical meeting might proceed in the following fashion:

For the first few minutes, the boys would sit around the room, with Jerry, the president, shouting for order. Larry, isolated from all the hubbub, would be working on a plane. James and Bruce, the two passive boys, would remain physically close to the leader and with excited smiles would watch the antics of Dick, Jim, and Wes, who would be pummeling or chasing one another. Jerry, caught by his own ambivalence between wanting to do what they did and the responsibilities for law and order that he felt his position called for, would do nothing. It was apparent that the motivations for Dick's and Jim's uncontrolled behavior had a common factor—namely, their perverseness and their hostility and hatred for adults as objectified by authority. Jerry would finally enter the struggle, probably in open capitulation to his wish to do as they did, but with a thinly disguised rationalization of establishing law and order.

The chase and fighting would sometimes spill outside the basement room. Dick might chase Jim outside, with Jerry and Wes in hot pursuit. However, since Dick had no loyalty of any sort, he might just as easily shift his interest to slamming the door upon the heads of Wes and Jerry, his erstwhile aides. He would not hesitate then to call upon Jim for help.

After we had evaluated the character of Dick's hostility and the level of interpretation that was necessary to draw Dick and Jim, too, back into the meeting, there was little doubt that they could not fit into a typical classroom. They were simply unable to withstand the tension generated by their own feelings. Further, it was abundantly clear that Dick could not be managed by a control-identified teacher, since his hostility against all authority was too great.

A second incident illustrates another area in which a teacher-trained group leader would experience difficulty. One

day while the group was out walking, a discussion started regarding conception and birth. With the exception of Jerry, who had had ample opportunity to observe both coitus and delivery, the other boys were firmly convinced that all sexual activities were centered in the anal region. This concept was strongly supported by the passive members. That this not uncommon idea reflected more than the usual confusion was confirmed by cessation of the discussion and a spontaneous outburst of song from several of the boys. The theme of the song was, "We lost our balls in the Navy and now we are girls." This meeting was closed by an extremely sadistic performance on the part of Dick and Wes. The two boys caught a cat and used it as a soccer ball. Before the leader could intervene, the cat was dead.

Problems that developed within the group, and those that extended themselves out of the club into the schoolrooms, forced the termination of the experiment at the end of one year. It had become quite apparent that the therapeutic-group atmosphere could serve only to stimulate a degree of acting-out that the school could not tolerate or be expected to understand. The depth of the serious pathology of several of the members was now known. In so far as the passive boys were concerned, the degree of anxiety engendered in them militated against the club's continuation. In summation, it had become clear that the most seriously disturbed youngsters could not be helped by this particular therapeutic regimen without causing additional problems for the school. It should be noted parenthetically that the amount of aggressive behavior was not excessive in the light of the degree of the disturbance manifested by the boys. The quantity of disturbance occurred within and was consistent with the group leader's experience with similarly disturbed groups.

It is interesting to draw comparisons between the teacher's report of a child's behavior and the therapist's impression of the same child at the conclusion of the club experiment. It is freely admitted that there were obvious differences in control elements present in the two situations, but it should be emphasized that both judgments related to group behavior, and must be interpreted as an expression of the child's relationships with other children. It is then pertinent to consider

the presenting problems as seen by the teacher at the time of referring the child.

For example, the teachers' statements about three of the boys point up the marked discrepancy between the difficulties evidenced and the underlying pathology. Let us consider the teacher's picture of Jim. He was described as a clown, silly, and scholastically backward. The group-therapeutic experience revealed a boy who had lost confidence in and hated every adult, who was overwhelmed with guilt by his belief that he was responsible for his parents' divorce, and who was filled with feelings both of worthlessness and of suspiciousness. Jim was compelled, out of his tremendous hostility and his guilt, to destroy any possibility of a positive relationship. Like an iceberg, his problem extended to depths that were little indicated in the classroom. His behavior in the therapeutic group gave a somewhat better depth sounding. His extreme unhappiness, his irrational hostility, and, most important, his complete inability to extend or to receive any positive feelings were portents of the future.

The group did little to help Jim directly since he could not share the leader. After the dissolution of the club, his group adjustment continued to be poor. Only through our constant interpretation to and support of the teacher did Jim make any progress. An attachment to a friendly, warm, and undemanding male instructor was of immeasurable help. The teacher was able to support Jim only after he had been helped to understand the boy's difficulties and his need for a one-to-one relationship.

Yet the strength of Jim's self-destructive impulses became intensified, particularly as he entered adolescence. Accidents began to occur, including a severe fall down steps, numerous cuts, and a near-blinding in solitary chemical experiments. Under the influence of a delinquent acquaintance, Jim began some petty stealing. He was finally arrested by the police, when he was caught, paralyzed with fear, on the floor in the back of a car. At the friend's suggestion, he had planned to strike the woman driver over the head and steal the car. Over his mother's protests, we were finally able to have him removed from the home and sent to his paternal grandparents.

Dick had been referred to us as a result of two instances

of problem behavior. One was the stealing of the classroom's petty-cash box. The teacher felt that this incident had been satisfactorily resolved by Dick's agreement to repay weekly from his non-existent allowance. The other problem was his bickering in class with his younger brother who, as a result of Dick's poor school work, was now in the same grade. In general, the teacher felt sympathy for the boy, along with a benevolent hope that she could save him from the effects of his poor home.

In the club, Dick clearly evidenced his inability to relate positively in any way or to accept positive feelings. He was vicious and uncontrolled in his attacks upon the more passive boys, particularly James. All of the group were quite impressed by his completely irrational stubbornness. An example of this could be seen in the use of the club car. It was agreed procedure that the boys should alternate in the use of the front seat. Dick would jump back into the front seat on a return trip, although he had already had his turn. The other boys would threaten him, beg, plead, and cajole. He would sit with his arms folded and look ahead without saying a word. It is difficult to explain the effect of such irrationality upon the boys. They were aware that Dick complied with no rules of any kind.

Generally, he could not verbalize his feelings or thoughts. He would either run away or become stony-faced in a situation in which he was in any way at a disadvantage or threatened. Any show of authority toward him evoked utter defiance. There was little doubt that, in some ways, he was nettled, disturbed, and confused by the non-interfering and non-moralistic attitude of the leader.

After the club disbanded, Dick found himself in increasing difficulties both in and out of school. Reports began to filter in to the therapist through the grapevine of former club members that he was stealing money from homes. Once, he was arrested and placed on probation. At the end of the second year after the dissolution of the club, his behavior problems forced a crisis in the classroom. His teacher, a warm, sympathetic woman, found herself flagrantly and openly defied by him. He finally threatened her with physical violence. A conference between the school, the police, and

Dick's parents resulted in a juvenile-court hearing. Dick, at the age of twelve years, entered a state training school.

Bruce, the excited observer, presented a markedly different picture from the above two boys and yet an equally serious one. Teachers had expressed no concern or special interest in his behavior. Bruce was brought into the club at his mother's insistence, as she felt him to be suffering as a result of her own matrimonial problems. He was outwardly highly organized and assumed responsibilities in the club. His differences made themselves known only through his lack of participation in the active play of the boys. He was a skilled conversationalist, but there was a constant need to exaggerate and to ascribe non-existent status to his family.

The other constant and important characteristic was his spatial relationship to the leader—Bruce was always next to him. From this safe vantage point, Bruce watched the rough-house antics of the other boys with an amused, but excited expression, and in the process made clear his great need to be identified with a masculine figure. He was most upset by the termination of the club, or, more accurately, by his separation from the leader.

Bruce's situation illustrates the inadvertent advantages and disadvantages of the club. Because we had no information from the school about him, we had been unable to place him in a theoretical and diagnostic framework. Through the club he became acquainted with his own problems and fought his way into individual treatment. It was found that his mother's seductive behavior had forced him into identifying with her in order to protect himself from his own anxiety.

Prior to, during, and subsequent to membership in the club, he entered into active homosexual relationships. One of these had endured over several years. Puberty, however, had brought him into open conflict, with resultant serious repercussions. His emasculated adjustment now brought acute anxieties. Attendance in class became disturbing—on the one hand, because of his homosexual wishes and excitement, on the other hand, because of acute castration anxiety. Considerable truanting inevitably followed and his scholastic work went into a sharp decline.

Fate granted a brief respite of six months via a mild case

of Osgood-Schlatter's disease. Since his condition necessitated leg casts, Bruce could not participate in sports and immediately became free from anxiety and a comfortable invalid. With his physical improvement, he began to fail scholastically and reëntered homosexual relationships.

James's difficulties require a brief note. He will be recalled as the boy who played with girls and clung to teachers and who presented no classroom problems. The club did little to help him; as a matter of fact, it made his life more unhappy. For example, James was an unconscious provocateur. His passivity and masochism stimulated Jim and Jerry to attack him. This activity carried over into the classroom of which they were all members. When it became necessary to remove James from the club and simultaneously to transfer him to another room, it was possible to explain the dynamics of his behavior to the rest of the group. Repeated explanations were necessary before they could understand that James's personality required these beatings. The group's constant complaint about him is of interest. They said, "He isn't fair because he doesn't fight back."

James remained unchanged in the years after the termination of the club. He found several other passive youngsters and with some sublimated outlets, he ceased to present any problem. The club was of specific help to him in another way, for both James and the teachers were assisted in understanding that his illness was similar to that of Typhoid Mary. They became familiar with his particular kind of personality structure and the part it played in stoking the fires in the classroom. When his teachers could be helped to see that James's passivity threatened his classmates, they could understand why other children reacted with instinctive aggression toward him. The increased objectivity of the teachers helped stabilize the situation.

One of the valuable contributions of the club was its use in lieu of parental information. One general characteristic of this group was lack of parental interest, coöperation, and understanding. The specialized atmosphere of the group helped to fill the parental gap and permitted the children to reveal their hopes and fears. This enabled us to be of additional help to their teachers.

Although, as we have reported, the careers of several of the boys ended unhappily, it must be said that the material secured from observation of the boys at the club immeasurably strengthened our discussions with the teachers. Suggestions with regard to the boys were based on solid premises and were of value. In the critical situations mentioned above, the group observations served the immensely important functions of strengthening loose thinking and dispelling the guilt of the teachers. Dick's teacher, for example, was extremely upset, since she felt responsible for initiating a chain of events that led to Dick's commitment to a training school. Our ability to help her understand how seriously disturbed Dick really was served to mitigate her guilt.

From the above discussion, it can be seen that there was a blatant disparity between the teacher's impression of the individual child and the observations of the group leader. We do not mean to suggest that the teachers were either professionally remiss or psychiatrically naïve. Instead, they had been participants in a program of mental-hygiene education reported elsewhere[1] which compared favorably in most essentials with national efforts in this direction. You will recall that the teachers' statements in referring the boys were generally descriptive in nature, avoiding, for the most part, any value judgments. Although some were lamentably brief, all represented a sincere effort upon the part of the teacher to understand the behavior of a particular child. From the analysis of these differences, two major questions arise: (1) why should there be such a difference between therapeutic and educational orientations in the matter of behavior evaluation; and (2) what does this difference portend as regards the possibility of utilizing teachers as group therapists?

It became apparent to us that the teachers' observations of children in groups lay in a somewhat different direction from those of the group workers. Several factors contribute to this state of affairs—factors that point to a possible clarification of prevalent confusion regarding the group rôle of teachers. Teacher education still bears vestiges of the stamp

[1] See "Observations on the Psychological Education of Teachers in a School-Based Mental-Hygiene Program," by M. L. Falick, M. Levitt, B. O. Rubinstein, and M. Peters. MENTAL HYGIENE, Vol. 38, pp. 374–86, July, 1954.

of John B. Watson, whose concern with only observable reactions impeded real understanding of the child for more than a decade.

Further, teachers taught to observe only surface behavior were often left floundering in the shift to depth psychology, and became uncertain about what they were expected to see in, or even to do about, unusual child behavior. Even those who could make this difficult synthesis were not infrequently trapped into assuming a one-to-one relationship between unconscious strivings and behavioral manifestations.

Jim's teacher who saw him outwardly as a "clown," seeking affection and attention, made a very plausible error in assessing the basic expression of this boy's needs. It was as if the teacher said, "Jim seeks attention. Hence, he must need it." This quantitative judgment could be only mechanically correct, for it overlooks "the dynamic relationship between impulses and the attitude which the child's ego and superego have adopted . . . toward them."[1]

It was undoubtedly true that Jim sought attention and affection and so the first part of the teacher's formulation was correct, for this was the readily observable portion of his personality. Teachers are on solid ground here; the statement is descriptive and any observer would be forced to agree that Jim sought attention. The error comes in the assumption that Jim's needs were as simple as those of other children who behaved in like manner. Hartmann and Kris[2] put it so succinctly: "Extreme aggressiveness may in one case be the reaction to fear and its concealment, in the other, the direct expression of sadistic wishes." Only the genetic analysis of Jim's developmental experiences could bring understanding of the interaction between instinctual life and mechanisms of defense against its expression.

Stated in another way, Jim really did not want attention, *per se* (the surface symptom); he really sought to prove, in paranoidlike fashion, that those who appeared friendly to him would soon turn against him. That the overt expression of

[1] See "The Contributions of Psychoanalysis to Genetic Psychology," by A. Freud. *American Journal of Orthopsychiatry*, Vol. 21, pp. 476–97, July, 1951.

[2] See "The Genetic Approach in Psychoanalysis," by H. Hartmann and E. Kris, in *Psychoanalytic Study of the Child*, Vol. 1. New York: International Universities Press, 1945.

a deep-seated conflict frequently is accepted as its cause must be related to the nature of the teacher-training process, with its mixed and often confusing emphasis upon understanding group psychology through very general elaborations of individual psychology.

The fact that teachers emerge from this process understanding very little about either the individual or the group has been remarked upon by several other observers, notably Redl in *Discipline of To-day's Children.*[1] Thus, it begins to appear that the difference between two professional observers (teacher and therapist) was more than one of orientation or opportunity. More basically, we felt, it had to do with training and with the depth of understanding of psychic interrelationships. In short, it is more than a matter of pluses and minuses. The teacher's traditional concentration on surface behavior allows for gross distinctions to be made between children, but closes the door to delineation and understanding of the multitudinous nature of the possible adjustments between instinct and ego.

We do not mean to suggest, however, that the training of teachers be redirected to the area of explorations of the unconscious motivations. Any observation of educational relationships demonstrates clearly that the teacher deals primarily with the outward and manifest expression of the child's personality—*i.e.,* with mechanisms of defense. Most serious students would, moreover, agree that this is how it should be.

This brief discussion points the way to one of our major conclusions regarding the possible use of teachers as group therapists. We were forced to agree that the transition from an educational to a therapeutic rôle could be made only with the greatest difficulty. It was not that all the teacher's earlier training was detrimental; it was only that the necessity completely to restrain, or possibly to refine, the traditional focus from surface to below-surface explorations posed an overwhelming problem in relation to time as well as to teachers' capabilities.

Further, it must be noted that the various technical factors in therapeutic-group relationships require such a highly specific type of understanding that even skilled individual

[1] Washington, D. C.: National Education Association, 1944.

therapists frequently find themselves at sea in change-over attempts. The peculiar nature of the contagion process stands as an illustrative point in this regard. Control-wise teachers fear the contagious element in children's behavior, and well they may, for the spread of aggression may seriously impede educational sublimations. The therapeutic leader of groups, contrariwise, may seek to encourage this group phenomenon for treatment reasons, while he carefully assesses individual reactions to its outbreak, and makes use of them in interpretative comments to the participants.

A careful consideration of these factors leads to the inescapable conclusion that the current level of teacher training and understanding allows for only limited success possibilities in such a therapeutic regimen as we originally conceived. We were faced with the realization that the most gifted teacher, psychologically speaking, might possibly function as a therapist, but certainly could not operate as a therapeutic-group leader and an educational leader at one and the same time.

Our evaluation of our work in the light of our original purpose led us to the following conclusions:

1. We found that, as a diagnostic and prognostic aid, the group was of definite value. It was possible to obtain clearer impressions of the extent of the disturbance in the child and to make more accurate predictions regarding adjustment or treatment probabilities. With these particular children, the club provided us opportunities to make observations and form judgments that could not have been provided in any other way. Teacher and parental observations have a different focus. The latter were often not obtainable. Individual therapy—though it, of course, eventually provides one with insight into the deeper layers, the inner conflicts, strengths, and weaknesses—does not provide equal opportunity for observations of pathological group relationships and acting out. Children generally do not report such behavior, and it is difficult to get accurate and objective observations from parents or teachers.

2. We recognized that, both individually and collectively, there was little therapeutic gain from the group experiences. It is true that progress was made in some cases, but by and large the results must be classified as neutral or negative.

The therapeutic failure may be attributed, at least in part, to the peculiar nature of the influence of the school environment upon the therapeutic regimen. The requisite permissiveness in the group unavoidably carried over into the classroom, with resultant added burden and confusion both for teacher and for child. Even though an attempt was made to alleviate this situation by having the group meet outside the school proper, the problem continued to be troublesome because of the close contact the boys had in classroom and playground. This contamination of school behavior by club behavior became such a potent destructive force that the experiment had to be abandoned.

3. The insight that we gained from the deeper study into the pathology of each child and its effect on his group relationships was valuable in enabling us to help the teacher deal with the child in the classroom. Specific suggestions regarding the realistic handling of a problem could be made. The anxiety of a teacher who had felt inadequate could often be alleviated by a discussion of some of the underlying conflicts to which the child was reacting. As a result, the teacher became less subjectively involved, less frustrated, and could approach the situation more realistically. The very fact that we indicated a very poor prognosis in certain situations provided some relief of tension, with resultant easing of the problem. Since the child could do no better, less was expected of him.

4. In the light of the difficulties encountered by the group therapist in regard to transference, acting out, and contagion, it became clear that the training of teachers—which focuses, of necessity, on ego support, reality limits, and the furthering of sublimation through intellectual achievement—precludes their participation in a program aimed at reëducation (therapy) of distorted control patterns. Highly specialized training with quite a different focus is required of a group therapist. In addition, our experience indicated that group therapy, at least with seriously disturbed youngsters, should not be carried on in connection with or in a school setting. Despite some prevailing ideas to the contrary, the inherent value of school groups is educational rather than therapeutic. A teacher cannot be a teacher and a therapist at one and the same time.

WORK AS THERAPY, WITH SPECIAL REFERENCE TO THE ELDERLY *

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IN this paper I will discuss the psychogenesis of play and work and their rôle in maintaining psychic equilibrium. I consider this central to an understanding of the crucial problem of retirement in the elderly.

Play is a manifestation of a fundamental and omnipresent human urge—pursuit of pleasure—and is first seen in the random movements of tiny infants. With further maturation of the nervous system, these disorganized and explosive discharges of generalized tension are systematized into obviously pleasurable, but still simple and spontaneous activities, such as toying with various body parts and excretions. At this level pleasure is largely an immediate sensory gratification, predominantly, but not wholly, limited to tactile and kinæsthetic sensations.

As learning and experience accumulate, play becomes more complex. In addition to immediate sensory gratification it begins to serve as an outlet for intense sexual curiosity and for growing sexual and aggressive urges. Children's games that serve such a purpose—"playing doctor," "playing house," and "playing school"—permit the acting out of investigative and assaultive patterns otherwise frowned upon. Thus, playing games is a way to overcome childhood anxieties and fears often associated with guilt-laden feelings toward parents and other large and powerful adults. These seemingly irrational, but understandable, fears of childhood are surmounted largely through identification with the aggressor in the play situation.

We see, therefore, that in addition to evoking the immediate experience of pleasure—first, by reducing states of physical

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tension through motor discharges, and second, through the stimulation of specifically agreeable sensations—*play is a medium for the relief of psychologic states of tension.*

Work grows out of play and incorporates many of the above attributes. In fact, in such spheres as competitive sports, deciding where play ends and work begins becomes a semantic exercise. The feeling of achievement that develops very early in play becomes one of the important attributes of work. To illustrate, when a baby shows his dexterity with the cradle gym, his parents praise him, thus reinforcing the baby's pleasure in the approved movements. This achievement pleasure is a vital step in the development of reality adjustment, for it is largely through recognized achievement in chosen work that a person ultimately makes his place in society.

The fundamental changes that play undergoes in becoming work are connected with modifications demanded by reality. The essence of the change is development of the ability to "bind" or tolerate physical and psychologic tensions and to relinquish immediate gratifications for future rewards.

Work capacity develops in large measure from the necessity to adapt to society. Therefore, I look upon work as primarily a socio-cultural demand which, because of its origin in play, incorporates partial fulfillments of certain physiologic and psychologic needs. Although an aversion toward work is observable in most people—and is especially evident when there is a choice of immediately pleasurable activity—the demands of reality are such that a majority of persons are able to bridge the gap from play to work, first through externally imposed discipline and later by self-imposed discipline.

Apart from its subsistence value, work serves to bind one to reality and justifies one's existence within the group. It furnishes a whetstone for sharpening mental and physical capabilities and skills; it often leads to new and creative interests. But we must not forget that work also provides for substantial discharge of aggressive and erotic impulses.

Occupational Choice.—Although persons in our society ostensibly exercise "free" and conscious choice of occupation, many influences narrow the field of free decision. Economic necessity and educational handicap may limit avenues of expression; or the immediate cultural milieu may provide

significant pressure, as illustrated by the long lines of physicians, jurists, pedagogues, or even circus performers in certain families. But for my purpose in this paper, I wish to stress the unconscious motivations that influence occupational choices, since these are among the enduring motivations throughout the life span, varying only in degree with progressive physiologic quiescence and emotional maturation.

The psychoanalytic study of physicians, for example, discloses many unconscious determinants in our occupational choice. The deepest instinctual roots are erotic urges which may retain their strength in relatively energetic form and find partial fulfillment in our daily work. The everyday taboos of society are modified for the physician. Our daily work is in a sense a constant transgression of the ordinary prohibitions. The examination of the naked body and all its orifices; looking at, probing, cutting, removing, remodeling organs of every description; handling urine and feces—these are commonplace in our daily schedule. But our technical, scientific, and ethical training superimposes a form of conscience upon us that makes it necessary to deny this pleasurable aspect of our work. It is none the less there, though the large social value of our work obscures this important component.

The child mind seems to understand more than we credit it for; hence the popularity of playing the "doctor game." The child feels that the doctor is allowed all the ways of getting pleasure and expressing aggression that the child himself is denied. There are particular specialties and procedures in medicine in which aggressive and erotic impulses can find partial and even relatively undisguised fulfillment, while a socially acceptable and necessary job is being done.

Other unconscious psychologic determinants are sometimes discernible. The need to feel omnipotent and to have the power of life and death over one's "subjects," so to speak; the escape from the rôle of patient by becoming the doctor; the reaction formation to a need for mothering by "mothering" every one else—all these constellations arising out of the specific life history of the individual may be deep tributaries that finally find egress in the occupational choice of physician.

These unconscious tributaries are not the *sole* determinants that make us choose the profession of healing—which generically might include nursing, veterinary medicine, and the ministry. I must reluctantly recognize that under less fortunate circumstances some of these same unconscious determinants might lead one to become a butcher or a vice-squad officer. I do not wish to imply that one is imperatively and unconsciously driven to a single specific profession. Rather, groups of occupations have clear, psychodynamic similarities, allowing for wider—and *apparent* freedom—of choice and the expression of conscious interests and known talents.

In a wider sense, all human play and work patterns—whether unconsciously determined, "freely" chosen, or imposed by accidental circumstances—serve as a necessary outlet for many unconscious urges, needs, and impulses.

Disturbances of Play and Work Patterns.—Disturbances of play and work are among the commonest complaints the psychiatrist hears. Inhibitions, distortions, and exaggerations of work and play are seen, though not all need psychiatric treatment. The obsessive exactness of some accountants or research workers, the ritualistic cleanliness of some surgical nurses, represent a kind of auto-therapy. This manner of performance may serve as an adequate defense against the eruption of underlying emotional difficulties.

The *manner* of performance, no matter what the occupation, is crucial. The quantity and quality of application must be evaluated to separate the neurotic from the "normal." Does one work too much or too little? Is there a flexible and gratifyingly efficient application determined by the realistic requirements of the task, or is there a continuous, compulsive, ritualistic performance, regardless of the realistic demands.

Excessive frustration or overindulgence of an activity by parents may provide the pattern for psychopathology. Play may be looked upon by some parents as a frivolous and unprofitable activity—especially when the play is connected with autoerotic stimulation, particularly in masturbating. Such parents lay down firm, punishing interdictions. It is no surprise that some people never learn to play, for growing up in a climate of cold austerity and dutiful work, created by

stern, guilt-laden parents, is a formidable obstacle. In such cases play evokes too much guilt.

People with play inhibitions may show a zealous overdevotion to work. They work furiously and are sometimes described as people with great drive. Closer examination reveals a guilty need to work unceasingly. This type of "all work and no play" has serious shortcomings, and folklore has it that it makes Jack a dull boy. The inner feeling of moral compulsion robs the activity of all wholesome pleasure. It is possible that these people may periodically be unable to work at all. In certain circumstances the inner rebellion against the parents who firmly prescribed and demanded dutiful, unpleasureful work may demonstrate itself in work-paralysis.

Work inhibitions also may be related to deep-rooted difficulties in handling aggressiveness and self-assertion. Growing up where "children should be seen and not heard" may lay down the pattern wherein qualities of self-assertion are submerged, healthy ambitions are stultified, competitive urges cannot be tolerated, and work of the most sheltered and ungratifying kind is chosen. If anything more ambitious is attempted, failure results.

Some parents may overindulge play activities, failing to provide sufficient stimulus for the child to bridge the gap from sheer pleasure to reality. Thus wholesome work patterns are not established. Overindulged individuals are not neurotically inhibited in their work capacity; rather, their play activities have not progressed to the work level, and they remain fixated on the immediate pleasure plane. Characterologically, these people are excessively passive and dependent.

Work Therapy Defined.—In this paper, the term, work therapy, is used in its broadest sense and includes one's specific work or profession and recreational pursuits, in addition to the more purposefully prescribed activities to which the term, occupational and recreational therapy, is generally limited in its strict application.

Occupation *is* actually therapy when viewed within the framework of its genesis. I think it will be generally agreed that, in our culture, work is one of the foremost sublimations

available to us, serving as an essential way of finding fulfillment of primitive aggressive and erotic needs. It may be a defense against obscure inner weaknesses, thereby aiding in a socially acceptable mastering of reality.

Pursuit of one's occupation may be wholesome and mature or it may be neurotic; in any case it plays a vital rôle in the life of any person.

If reality is "mastered" by excessive emotional investment in one's work, especially if it be to the exclusion of other values and interests, it may be difficult or impossible to give up work without neurotic disturbances. Life may be looked upon as a continuation of adaptation, wherein one may have to give up certain satisfactions, adjust to new demands, and find adequate gratification therein. The person who cannot substantially renounce or modify his work pattern is also the one who had difficulty in renouncing the breast for the bottle, the bottle for the cup. He had difficulty in renouncing the pleasures of the nursery for the greater responsibility of more formal schooling; the security of the parents' home for the responsibility of marriage and his own family. In a larger sense, he has difficulty in renouncing the ambitious, competitive strivings of youth for the quieter tempo of older age. I might surmise that it is this same person who cannot accept the possibility of individual death, for death also is another step in the adaptation continuum.

Retirement and Its Implications.—People in certain professions fortunately never need to give up their work entirely, but can continue at a tempo commensurate with their general vigor. Persons in highly individualized pursuits, such as artists and writers, are examples. This is perhaps the main reason why these pursuits have such great value as avocational interests. But most people are employees and work within a hierarchical setup wherein the press of competition and the battle for position set the pace. This is as often true in universities and in hospitals as it is in industry. We live in an epoch of dis-individualization fostered by the credo of high-powered mechanical efficiency, wherein quantity and speed are the watchwords. Hence, compulsory retirement has so far been prevalent in our culture.

It is my thesis and recommendation, however, that our

efforts must be devoted to changing this procedure, since work and play are so essential to psychic balance. It is possible that innate physical vitality may allow survival, but life can be added to years only through the perpetuation of play and work activities. I would also surmise that physical survival is fostered by the psychological assist resulting from these activities. In general, I would say that retirement from one's lifelong work is a psychologically unsound idea.

Retirement is often looked forward to eagerly, but generally loses its flavor as it approaches. The best adjusted people feel it as a blow, when lifetime work patterns must be relinquished. To those for whom the work pattern was the bulwark of their defenses, retirement may precipitate psychologic reactions, varying from intense depression and hypochondriacal preoccupation to overt psychoses. Often it seems as if true senile organic deterioration is catalyzed by retirement, a psychologic catalyst for death.

For some, there are favorable factors in retirement. When one is no longer responsible for a growing family and has a lessened need for income, one feels free for the first time to pursue interests to which, during one's working years, one was able to devote only an occasional "stolen" hour. One can throw off patterns of constraint built up over the years and take stock of abilities and interests that have lain fallow during the so-called productive years. In some cases of successful retirement, a leisure-time occupation has emerged as a new and more interesting vocation. This is possible for persons for whom work was not an obsessive, compulsive, defensive preoccupation.

In most instances, the older worker finds that he is waging a losing battle against competition from younger and more vigorous people. He must exert greater effort to complete the tasks assigned him. Traveling to and from the job is more of a strain than it was in the past.

The realization that he is slowing down physically causes anxiety that he will be unable to keep up with younger employees and will lose his job. This anxiety is reflected both in work performance and in relations with younger workers—the interlopers who are seeking to uproot him from his position. Retirement permits an acceptable withdrawal from the

competitive arena without loss of status in persons who have resolved satisfactorily their own adolescent competitiveness.

Prescribing Therapy.—Obviously not every one will require treatment. Some elderly people have achieved a harmonious self-acceptance by progressively "making the grade" in the adaptation continuum. These are persons whose personalities did not require obsessive application to a single specific occupation. Their collateral interests began early in life and were nurtured through the years. Such collateral interests continue to have a vital, sustaining value at retirement time.

It is easy to say that one should do this or that early in life in order to develop broader interests. However, the ability to develop collateral interests goes along with character maturity and flexibility and with relative freedom from neurotic inhibitions, compulsions, and phobias.

Our essential task is to find activities syntonic with the psychodynamic structure of the patient. First his background, his occupational and avocational choices, and his former adjustments, must be studied. The current symptomatic picture may modify our prescription temporarily, but with alleviation of symptoms and greater stabilization of adjustment, the prescription will also change. The best type of occupational therapy is based upon the patient's former occupation or some modification thereof.

Older persons have many abilities that can be utilized. In Haverhill, Massachusetts, a non-profit group known as Sunset Industries have converted an old school building into an apron factory which now employs 24 elderly women. (The number will soon be increased to 55.) An insurance company in Massachusetts plans to staff its claims-examining bureau with personnel over sixty-five. A business man has employed 200 retired draftsmen living in Florida in a plant he has established there. Other business men have gone to Florida and secured skilled older workers for plants in their own states.

It is to be hoped that there will be a continued growth of projects creating job opportunities for the aged; there is ample evidence that such projects are not at all necessarily philanthropic; they make constructive and profitable use of the skills and experiences of the elderly.

Some elderly persons are not easily integrated into projects of this kind. It may be possible to continue with the same or similar occupations on a reduced level in institutions and homes for the aged. In some homes for the aged, shoemaking, dressmaking, hairdressing, bookbinding, and printing are carried on, in some cases for profit.

The ritualistic, compulsive individual—perhaps a retired auditor—may enjoy and benefit from setting type in the print shop or building ships from matchsticks in the craftsroom. For such a person, prescription of exact schedules for exercise, diet, and hours of occupational therapy are also helpful, as these substitute rituals serve a defensive function in the psychic economy.

The narcissistic, exhibitionistic individual—perhaps a retired sporting-goods salesman—may accept and benefit from finger-painting, dancing classes, dramatic groups, or round-table discussions.

Other aspects of the patient's character and needs must be ascertained. The person who has found an outlet for repressed, angry aggressions in his occupation must be provided with a task that will fulfill the same purpose. Sculpture and finger-painting may help. Leather or metal craft, with cutting or hammering antiques, may be useful.

Appropriate reading material is also useful. Partial fulfillment of urges and needs can be met through identification with characters in the story. The popularity of Micky Spillane books speaks for itself.

To summarize, compulsory retirement, a procedure so far prevalent in our culture, is psychologically unsound. Its unsoundness is demonstrated by an exploration of the functions of *play* and *work*.

Play is a fundamental, omnipresent, instinctual function serving for the discharge of physical and psychologic tensions and for the fulfillment of deep-rooted psychologic needs. *Work* is a reality-oriented modification and outgrowth of play; like play it serves the psychophysical economy. However, the social value of work makes it more sustaining in its usefulness to the individual than play, although both are necessary. These needs and tensions do not disappear with aging, though

they may become quieter. Thus work serves a vital sustaining function in maintaining psychic equilibrium throughout a lifetime.

Deprivation of lifelong work patterns via compulsory retirement, at a time when the aging person is adjusting to waning physical and mental powers, delivers a staggering blow to his integrity. Old neurotic conflicts adequately surmounted through work are rekindled. Psychologic insult accentuates physical decline, and we have the "psychosomatic" syndrome of senility.

It is my belief that the growing problem of senility, the sick aged, can be assuaged and in some measure negated by continued work as a lifetime pursuit, except for those "normal" aged who voluntarily retire from some type of work into some other activity of their choice.

In homes for the aged and in those cases in which continued work is not practicable, occupational and recreational therapy, in its limited sense, should be extensively used, tailored to individual needs. Inactivity is a catalyst for senility and death.

A COMMUNITY EXPERIMENT IN PREVENTIVE MENTAL HEALTH

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FOR the last three years, the city of Denver, Colorado, has been the locale of an unique experiment in adult education —in the field of mental health. In a three-year period, over 25,000 total attendance has been recorded for thirty lecture-discussions on mental health. A brief history of the development and planning of this educational experiment might be of interest to those in other communities who are planning similar projects.

In 1949 and 1950, a mental-health committee of the Health Division of the Denver Area Welfare Council had been active. The Denver Area Welfare Council is composed of representatives of most of the Community Chest agencies in Denver and adjoining population centers, as well as of the various welfare agencies of the communities, and interested citizens. An informed public and better social conditions are among its goals. An education committee of the above mentioned mental-health committee had been working during 1949 and 1950 toward the end of making it possible for Denver adults to understand better the dynamics of human behavior and thereby enjoy better mental health. In 1950 this committee recommended that a series of free public lectures be arranged. Lecturers were to be well-qualified speakers—preferably psychiatrists.

Concurrently with the work of this committee, the staff of the Emily Griffith Opportunity School (the adult and vocational school of the Denver Public Schools) had been working toward a similar objective. For a number of years the school had been successful in offering free evening courses in home and family living, marriage relationships, and the like. The interest generated by these courses led to the belief that widely publicized lectures in the area of psychological dynamics and mental health would meet with community approval.

In the summer of 1950, the Mental Health Committee of the Denver Area Welfare Council requested representatives of the Emily Griffith Opportunity School to meet with them to discuss the possibility of offering a lecture series on mental health under the auspices of the Denver Public Schools. This meeting was held, and it was decided to form an advisory committee, first to decide whether such lectures were feasible and, if so, to assist in planning a lecture series.

This first advisory committee consisted of representatives of the Denver Area Welfare Council, the Emily Griffith Opportunity School, the Colorado Neuropsychiatric Society, the U.S. Public Health Service, the Colorado Department of Public Health, the Denver County P. T. A. Council, and several leading psychiatrists. After several meetings and discussions, the committee decided that the experiment was feasible and was needed in Denver. Then began the painstaking—and often frustrating—business of planning the lecture series. The details of planning lecture content and the content itself have no place in this brief report. However, the format of the lectures might be of interest.

The lecture series was entitled *Mental Health: Understanding Ourselves.* Titles of individual lectures suggest both the tone and the content: *Personality, What Is It?* (two lectures); *The Mind, What Is It?; Personality Needs, What Are They?; Teen-age, What Is It?; Effective Living in Adult Life,* (two lectures); *Age of Inevitability; Old Age—Enjoy Yourself; Mental Illness, What It Isn't;* and *Mental Health, Everybody's Job.*

These eleven lectures were planned to begin shortly after the first of the year (1951) and to be given on succeeding Monday nights for eleven weeks. The time (7:30 to 9:30) was to be equally divided between a lecture by a local psychiatrist, a different one for each night, and a discussion generated by written questions submitted by the audience. The psychiatrist was to conduct the discussion. It should be noted here that the last "lecture" was a panel discussion with a psychiatrist, a juvenile judge, a district judge, and two welfare-agency representatives on the panel. The lecturers and panel members planned their words to appeal to a lay audience with varying educational backgrounds. The series was given in

the auditorium of a centrally located junior-high school with a seating capacity of 1,200.

Prior to the lectures, 70,000 one-page brochures announcing the series were printed and distributed to all the public schools in the city. School children took these home to parents. Local radio and newspaper coöperation was secured to publicize the lectures. The public schools bore the expense of the enterprise and the lecturers donated their services in the public interest.

The lecture-discussions were a resounding success. The first year a portion of the audience stood in the overflowing auditorium for most of the lectures. Both the lectures and the question-discussion period were tape-recorded, and the Emily Griffith Opportunity School reproduced the lecture-discussions in multilith, paper-bound, and stapled form. These were offered for sale at $2.75 apiece for the eleven lectures. The sale of these books paid for the cost of production.

The advisory committee continued in 1951 with much the same membership and representation. It was decided that the saturation point had not yet been reached and that the series should be given again in 1952. The panel discussion was considered the least interesting and was dropped from the series the second year. In its place was substituted a showing of recent mental-health films. The two lectures on "Personality. What Is It?" were concentrated into one, as were the two on "Effective Living in Adult Life." Also, a lecture-discussion entitled, *Living with Children, How Can We?* was added. The title of the lecture, *Old Age—Enjoy Yourself,* was changed to *Life After Fifty.*

These changes resulted in a total of nine lecture-discussions and one film showing. The lectures were moved to a larger auditorium (1,800 seating capacity) in a high school. The location was still essentially a central one, but nearer to a large residential section. Parking facilities were better. The 1952 series averaged 800 per lecture.

This year also, a different approach was attempted. Sharing the hour lecture period with the psychiatrist was a lecturer from another walk of life. He, of course, related his comments to the topic under discussion. Three clergymen, an industrial personnel director, a college president, two judges, and a social-welfare director shared the podium. In evalu-

ating this procedure, the advisory committee felt that the audience members came to hear the psychiatrist and resented the relinquishment of any of the psychiatrist's time to others. Audience reaction indicated that the procedure was not particularly desired, and, therefore it was not repeated the following year.

The 1953 series was given at the 1952 location, and, again, the format was changed but slightly. In both 1952 and 1953, certain of the lecturers had changed residence and new recruits were added. Attendance in 1953 was about the same as in 1952, indicating that the saturation point had still not been reached. Psychiatrists alone conducted the lecture-discussions. Publicity methods and the issuance of bound reproductions of the series were repeated both in 1952 and in 1953. In 1953 the Colorado Psychological Association joined the sponsoring groups. The 1953 series titles were the same as the 1952 titles with two exceptions: *Personality's Bag of Tricks* was submitted for *The Mind, What Is It?,* and *The Halfway Mark* for *Life After Fifty.* The showing of mental-health motion pictures was also repeated.

The advisory committee has planned the 1954 series, using an auditorium in a new junior-high school in a different residential section. Several of the lecturers will be new, and the title of the series, as well as the individual titles, will be changed. The content of the lectures, too, will be changed in 1954, as it is felt that many adults who have attended the lectures during the last three years would attend some of the new series if the content and approach were changed. The newly born Colorado Association for Mental Health is sharing sponsorship of the 1954 series with the group previously named. The title of the 1954 series is *The Psychiatrist Looks at Life.* The individual titles will be: *A Psychiatrist Looks at Business; A Psychiatrist Looks at Art; A Psychiatrist Looks at Marriage; A Psychiatrist Looks at Children; A Psychiatrist Looks at Drugs; A Psychiatrist Looks at T.V. and the Movies; A Psychiatrist Looks at Normality; A Psychiatrist Looks at Alcoholism; A Psychiatrist Looks at Religion;* and *A Psychiatrist Looks at a Psychiatrist.*

There has been no official registration for any of the series. Denver adults have felt free to come to one or all of the lectures. There has been no "homework" or credit attached

to the lecture series. Every effort has been made to create an easy atmosphere on a "non-school," interesting lecture approach.

Several pertinent guide lines have contributed largely to the success of the Denver experiment and would be helpful in other communities planning a similar community-education program. Some of the most important principles adhered to were: (1) enlisting the coöperation of the adult-education department of the public schools, whose experience in planning and executing large-scale educational projects is invaluable; (2) circularizing parents through distribution of announcements by the schools; (3) setting up an advisory committee representative of *all* interested groups, whose sole responsibility is the planning and evaluation of the project; and (4) attempting to create an atmosphere that does not obligate the audience and that omits normal registration procedures, name-giving, tickets, etc.

The attendance figures of from 800 to 1,000 average attendance each year for three years, something in the neighborhood of 8,000 total attendance per year, and 25,000 for the three years, are mute testimony to the popularity and acceptance of the lecture series. The advisory committee, the public-school staff, the neuropsychiatric society, all agree that the over-all effect of the lectures has been a better-informed public, and greater interest in the area of mental health both of children and of adults.

Psychiatrists in practice report few, if any, adverse results of the lectures in individual cases. In fact, some therapists prescribe the lectures as a part of treatment. The over-all effect has been a wider understanding of human behavior by Denver-area residents and a more widespread understanding of therapeutic facilities. Perhaps one of the best outcomes has been a realization in the community that psychiatrists are earnest medical practitioners and can speak a common language with the man on the street.

THE PSYCHOLOGY OF CLOTHING AS A TREATMENT AID

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OF the three important physical necessities of civilized man to-day—food, shelter, and clothing—the last named, *clothing,* ranks very high in our modern complex age. Clothing enters into the very heart of our existence as social beings. Clothing not only protects the body as its *least* important mission, but the decorative effect of clothing builds up or tears down our ego, hurts our vanity or fosters our pride, depresses our daily life or brings joy and pleasure to our routine existence. The psychology of clothing can fortify the patient's self-esteem and can bring peace to his troubled soul.

This philosophy was the basis for a determined effort by Dr. J. T. Naramore, Superintendent of Larned State Hospital for the past ten years, to bring about improvement in the clothing worn by mental patients. The result was a complete revamping of the entire clothing department, which reached out into the purchasing of clothing, into reorganizing the laundry, and into the general care of clothing in all branches of patients' care.

Superintendent Naramore saw the need for this improvement in his first year as superintendent of Larned State Hospital. Ten years ago the total expenditure for *clothing* and *bedding* and *dry goods* was $7,323.29. In a breakdown, this would amount to the pitifully small and totally inadequate per-capita cost of $4.52 per patient per year. As of July, 1946, the patient population was 1,512. The per-capita cost went up the following year, 1947, to $17.26, but in 1948 dropped to $12.72. In June, 1948, the peak population total was 1,761. In 1949, the per-capita cost rose to $16.71, but dropped slightly in 1950 to $16.22.

All these years this per-capita cost included not only *clothing,* but *bedding* and *dry goods.* However, in 1951 a new budget system was adopted that showed *clothing alone* in dol-

lars and cents as per-capita cost. By 1952, Larned State Hospital was spending for clothing alone a per-capita sum of $18.52.

Keep this amount of $18.52 in mind as the total sum spent in one year on the clothing for one patient, man or woman. Then call to mind the hundreds of men and women you know who spend that amount on a hat or a blouse or a fancy sport shirt. Yet, in this hospital, spending $18.52 in one year on a patient's clothing was quite an improvement over the days when welfare patients, overlooked by county boards, sometimes received no new clothing during the entire year.

Once in a while, welfare patients received donations of clothing from individuals or club groups. None of the senders of clothing, however, realized the vast need for many sizes and many colors, and particularly for washable fabrics. The largest donations of clothing usually came after spring and fall housecleaning, when the donors sent the hospital their discards. Often summer clothes came at the approach of winter. Winter clothes usually arrived at the beginning of hot weather. Through these groups the hospital made valuable contacts and lasting friends, but the clothing gifts were often unsuitable. The hospital could, however, always use *unusable* clothing discards in rug-making and other occupational work.

These facts are stated merely to show that no large institution can operate efficiently on a volunteer basis. Gifts never come at the time and season of greatest need. Such clothing (bare necessities) as we did carry in stock in those earlier days were boxed and crated in a balcony overlooking the breakfast-food department of the old and crowded commissary building. We had 840 square feet for everything and everything was piled high. Often a male patient helped another male patient pick out a pair of shoes from a packing box without any care in the fitting. There were times when a patient selected both shoes for his left foot or took the right shoe from one box and the left from another. Formerly each ward was sent a month's supply of basic clothing—dresses, hose, shoes, regardless of size, shape, or color. The patients' clothing needs were taken care of collectively. This mass action led to inertia of choice, lack of pride, and loss of some personal ambition, a kind of fatalistic atmosphere—"What's the use?"

The hospital sewing department, with a small staff and hand-operated machines, could not turn out the quantity of clothing needed. When the budget department got through figuring costs, they found that it was cheaper to buy ready-made clothing by contract. For instance, they found that it was possible to buy shirts for men at one-third of the cost of making them in the institution's small sewing room. This was true of women's print dresses also. After this cost survey in September, 1952, the first large purchase was made of 60 dozen print dresses—assorted sizes and colors and different styles. The first purchase of men's uniforms was made in September, 1952, on specifications furnished as to sizes and styles. Five hundred gray gabardine trousers were purchased, with five hundred shirts to match. How proud the men were to have the new gray uniforms instead of the monotonous blue shirts and overalls, which some had worn for many years!

Step by step the clothing-improvement project gained headway. Purchase of individual lockers for three buildings—Geriatrics, Koch (housing TB patients), and Rush—gave the patients a boost in morale because they had one little place of their own in which to take care of their property, chiefly clothing. Small hand laundries were set up on wards, so that patients could wash their small things—a saving both to their clothes and to the regular laundry facilities.

During recent months, $40,000 worth of new equipment has been installed in the main laundry, including finishing machines. Shirts go back to the wards, nicely ironed and labeled for the *patient owner,* not with a ward marking, as was formerly the case. By the old system, a patient might wear a different set of clothing with every bath change. Usually the clothes were tumbled dry, not ironed. Sometimes the clothes would fit and sometimes not. Now there is a definite lift in pride, since each patient gets his own clothing, with his own name sewed to it, nicely laundered and wrapped in a neat bundle, the same as for other folks!

But without doubt the greatest step forward was the final evolvement of a central-supply clothing room arranged exactly like a retail store, with mirrors, fitting rooms, good lights, and courteous personnel to wait on patients just as store

clerks wait on patrons. Here there are approximately 4,320 square feet of space for display. The entire basement under Beers Building is now "the store," as patients like to call it. Walls, ceilings, and supporting pillars of the basement are painted a glistening white. Chartreuse drapes hang at the two fitting-room entrances. Rocking chairs in the shoe-fitting section have pillows to match the drapes.

It is a long step forward in therapy when mental patients are permitted and even urged to make their own decisions for the relatively simple act of choosing a print dress or selecting a pair of house slippers. Making decisions in what to wear is one step forward toward normal action. Men and women patients enjoy coming to the store to pick out dress or work shoes that are fitted to the individual foot. They have a choice of black or brown shoes or black or brown oxfords. They can select bed slippers in the colors they like.

Women patients like to come to the store where there is a choice of 500 or more dresses hung on racks arranged by sizes. The new dress is individually fitted to the patient and becomes her own. Her name label is sewed into it. This same dress is returned to her from the laundry. If the patient has selected the dress herself, she takes better care of it. She tells the nurse and the beauty-shop operator about her new dress and wears it proudly to the canteen, where most likely it will be the only dress of that particular size and color.

The psychological angle was a heavy factor in the decision to do away with the old sewing room. Formerly great bolts of one pattern, one color, one fabric were purchased. As long as the bolt lasted, all dresses were of that very same color and print. Any woman, mental patient or not, resents having other women wear dresses just like hers. We have had patients tear great holes in new dresses for that very reason—it was just like the dress of another woman in the ward!

When Larned State Hospital discontinued its institutional sewing room in the late spring of 1953, there was not any thought of giving up the sewing machine or the seamstress. There is use for both in every department of the hospital. One large sunny room in the basement "store" (central clothing supply) has been transformed into a workshop. Here some of the former sewing-room employees are always busy

repairing torn linens (sheets, pillow cases, and towels) or making alterations on garments requisitioned for patients of abnormal size. A few items, such as extra-large-size garments and special-order items such as insulin sheets, are correctly made here. In one corner are the marking machines, ready to label all clothes and linens. In another small room is the shop, in which shoes are repaired or built up or down to meet individual needs.

The storekeeper in charge keeps garments in neat and efficient order, arranged according to size, sex, and season. She takes care of all requisitions, keeps office records, and condemns damaged articles beyond repair. She takes a general inventory of her supplies about twice a year, although the store operates under the perpetual-inventory plan. She has a staff of four paid employees, not including the shoe-repair man and the operator of the marking machine.

This fiscal year (1953-54) Larned State Hospital has budgeted and is spending a per-capita sum of $46.50 for the patient population of 1,514 (811 men and 703 women).

This tremendous improvement in recent months in the clothing of Larned State Hospital patients arose, as we have said, from the humanitarian interest of the superintendent, Dr. J. T. Naramore, who believes that mental patients are basically the same as other patients. He believes that mental patients should be given the same breaks on more of the better things of life, including the psychological uplift that better and cleaner clothing gives to every one. He realizes that the community forms first impressions of the patients from their clothing, long before making any analysis of feature and speech.

To-day more and more patients are being psychologically prepared by this hospital for their return as active, productive citizens to the social community. They attend movies, recitals, concerts, basketball, football, baseball, and other sports and activities away from the hospital grounds in the very center of nearby communities. They are not set apart by ratty old clothes, ill-fitting shoes, and ancient hats.

To-day Larned State Hospital is pleased when visitors say, "I can't tell your patients from any one else." We thank them with the remark, "That was our aim."

DO TEACHERS CAUSE NEUROTIC CONFLICT IN CHILDREN?

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THE mother of the nine-year-old boy raised her hands from her lap and asked plaintively, "What can I do? Here's a boy in the fourth grade who won't go to school. There're tears every morning when I insist he go back. He's been absent two weeks. It just can't go on any longer."

She paused a moment and looked away. Her voice became hostile and her face tense as she answered her own question, "I don't want to sound critical, and I wouldn't want this to go any further, but I think it's his teacher's fault. She's so nervous and always picking on Bobby."

As a clinical psychologist who serves as consultant to three public-school systems, I have been witness to this scene many times, for whenever a child's emotional disturbance seems to be connected with school, the teacher is singled out for blame or at least regarded with suspicion. But just how much responsibility do teachers have in the creation of emotional conflicts—particularly those known as *neurotic conflicts?* These latter produce relatively permanent changes in the personality or disturbances of body functioning, and are not to be confused with such momentary conflicts as those over whether to do homework or watch TV. This distinction will become clear later when we describe the structure and content of neurotic conflicts.

To begin with, we must admit that many children do seem to suffer from emotional distress only during the school year and not during the summer vacation. Some have nightmares and walk in their sleep during the school months, but have quiet, restful sleep during the summer; others suffer asthmatic attacks from September to May and breathe more easily from June to August.

A puzzled mother of a five-year-old who had been in kindergarten for three months made a similar observation: "I've

checked with his teacher and according to her, nothing unusual has happened in school. But it certainly is funny," she added, shaking her head. "It's only since he began going to school that Johnny's been wetting the bed. I've never had that trouble before."

It seems clear, therefore, that the pupil-teacher relationship and school attendance do seem to play a rôle in the appearance of innumerable symptoms of neurotic conflict and distress. But what is this rôle? Does the teacher *cause* neurotic conflict? Does school attendance expose previously hidden immature areas of the personality? What meaning does "going to school" have for a child? Before these questions can be answered, it will first be necessary to examine the mental development of the child and the relevant features of the environment in which he moves.

The world of the child is far from the tranquil, carefree one it is naïvely and conventionally conceived to be; rather, it is a turbulent one full of conflicts. The needs and wishes of the infant and the young child demand immediate fulfillment, but parents demand more and more control, more and more postponement of satisfaction. Junior wants candy *now,* but his mother says, "After dinner." How and when to eat, wash, play, and sleep are socially prescribed, as is behavior toward each of the members of the immediate family and toward the stranger.

Some of the disciplines instituted by the parents are of a more crucial nature than others; included in these are weaning, toilet training, disciplines for the expression of sex and aggression, and competition with brothers and sisters. Each of these experiences involves the controlling of strong emotions and needs or the relinquishing of immediate personal satisfaction for the love of another human being. These are learning experiences that influence all later personal relationships, for all intercourse between human beings involves to some degree the mutual controlling of emotions or inhibiting of behavior.

But as a learning experience, none is more important than the experience of adjusting day by day to the personalities of a mother and a father. This mother and father are much like every other mother and father in our culture, but they are also different from every other mother and father in the

whole wide world. And so their child will much resemble other children, but he will also be different from any other child ever before created. Parents help in the forming of the child's own individual conception of himself as a unique being and are responsible for much of his satisfaction or dissatisfaction in being what he is—"good" or "bad," artistic or athletic, successful or unsuccessful, a boy or a girl.

This creative influence is exerted by parents because the child enters the world completely dependent upon them for love, for nurture, for defense against all dangers—in short, for life itself. Parents are the first recipients of all the love and the hate of their offspring, so that, given the child's love seeking and the family constellation, one of life's earliest love triangles is created. Between the ages of three and six years, most children begin striving for the love and attention of the parent of the opposite sex and are fearful and jealous of the parent of the same sex. For example, a boy wants all of his mother's affection for himself and resents any of his father's attentions to her. A great conflict is created for him, however, for he is aware of his mother's love for his father and of his father's love for him. Within the boy, love struggles with guilt and hate with fear.

The intensity of this emotional struggle diminishes as the child gradually accepts the hard facts of life that in reality mother and father belong more to each other than to him, and that insistence upon having his own way may result in punishment from the father. Therefore, the child begins the quest to find his greatest love outside of his own immediate family. But this may be a Herculean task, and for many it is never achieved. Those who are unsuccessful are still tied to mother's apron's strings (or buckled to father's belt) and are incapable of finding happiness and pleasure in marriage. Whether a child is able to give up his infantile love desires and find happiness in a mature love relation depends upon the presence or absence of his mother and father, upon the way his parents love and punish him, and upon the way they love each other—in short, upon the kinds of person they are.

This would seem to argue that if parents were themselves happy and mature, they would be assured of a happy child who would become a mature adult. This is true to a large extent, but it does not invariably occur. Even with the best

possible of parents, a child may become emotionally disturbed, for more important than what actually happens to the child is what he *thinks* and *imagines* is happening. He is not just a plant which responds directly to the quality of its care. Instead, he is an active, insistent being, possessed of a mind that can reflect upon the care he receives. And in this mind surge intense love and hate, primitive sexual wishes and fears, magical thoughts about cause and effect, and ideas of omnipotence or self-destruction.

Sometimes this child feels of no more importance than a grain of sand, while at other times he feels that the world was created only for his benefit and pleasure. Little wonder that a child's very own thoughts sometimes frighten him! And he is just as apprehensive that because of their superior mental and physical powers, his parents may become aware of his innermost thoughts. He is a staunch believer in all forms of mental telepathy and clairvoyance. And why not? Mother always seems to know what he is doing and what he is thinking. Let him just slip into the garage and begin investigating the left-over cans of paint and Mother's voice is sure to ring out, "What are you up to? You're not in those paint cans again, are you?" And mind you, she couldn't even see him! And sometimes Mother says, "Don't climb that tree or you'll fall." He climbs and he *does* fall. How could she have known? He falls many times and often the pain makes him cry, but Mother says, "Let me kiss it, and the pain will go away." And the pain *does* go way. There are no limits to what Mother can do.

We have referred above to the turbulent, conflict-torn character of a child's mind, and it is now clear that these conflicts consist of opposing, antagonistic thoughts or emotions. The conflict is between the urge to indulge in some pleasurable, satisfying thought, emotion, or behavior and the fear or guilt to which it gives rise. The specific content of some of these conflicts we have already delineated. Now if a child is aware, or partially aware, of his conflicting thoughts and emotions, he may use up so much energy attempting to resolve or avoid them that he becomes tired and worn out. Small wonder that he has little zest for learning to read and would rather gaze out of the window.

But children do not sit and stew for long; they usually

begin to do something to get rid of painful fear or guilt. One thing that a child may do when the pressure of guilt becomes too great is to seek and welcome punishment. To make certain that punishment will be swift and sure, the pupil misbehaves in full view of the teacher; and thus, properly exorcised, he is temporarily relieved of the burden of guilt.

More permanent relief from unwelcome, painful ideas or feelings may be sought in attempts to drive them out of the mind. Translated into psychological terms, ideas and feelings are *repressed* and become *unconscious.* When ideas or feelings become unconscious, one is unaware of their presence. Once repressed, ideas are no longer under adequate control nor are their accompanying emotions suitably released. More significant for development, emotional maturation ceases, and the way in which emotions are expressed, and the persons toward whom they are expressed at the time of the repression, determine how they will continue to be experienced and expressed. A boy who represses a hatred of his stern father is no longer aware of his anger, but may thereafter have difficulty in relating himself to authority. In school he cannot take direction from male teachers and is a class nonconformist; later in life he quarrels with his bosses and is frequently fired for insubordination. We perceive that his childhood father is represented by every one in a position of authority, and toward them he now expresses all of his pent-up anger.

Repressed ideas and emotions are not always expressed in behavior; often they use a physical or a physiological means of release and cause all kinds of functional disturbances of the body—*i.e.,* pain, tics, gastrointestinal disorders, sensory and motor disturbances (including speech disturbances), allergies, headaches, *ad infinitum.* These symptoms can take on the guise of almost any physical disease or pathology and are sometimes mistaken for them.

Repression is not the only way in which a child may keep his thoughts and feelings out of his mind; other methods—or *defenses,* as they are called—are available to him. These other defenses, however, enable him to disown rather than to deny the existence of unwelcome thoughts and feelings. The child may *project* his own feelings onto others and feel picked on: "Nobody likes me, and the teacher blames me for every-

thing that happens." He may *displace* a fear of his own emotions to situations outside of himself so that phobias result, and now there is a fear of the darkened movie auditorium.

Displacement of hostility commonly occurs; the third-grade boy who is unable to hit his younger brother may pick fights with the boys on the school playground. And when questioned by his teacher about his bullying tactics, he *rationalizes*—that is, gives fictitious or minor reasons for his behavior: "I hit Joe because he's always showing off."

Strangely enough, a child sometimes defends himself by expressing emotions or attitudes just the opposite (a *reaction formation*) of those he really has. Fearful about controlling his aggressive wishes to soil and mess, he refuses to put his hands in the finger paint or gets very upset over having a smudge or an erasure on an arithmetic paper.

The defenses we have here enumerated are those most commonly used for protecting one's self from guilt- or fear-provoking emotions or ideas.

These attempts to handle conflicts by repression or the other defenses are never fully satisfactory, for no adequate solution to the conflict has resulted; it has only been rendered more or less unconscious. The individual who persistently uses these techniques is said to be neurotic. A neurosis is an inadequate way of life, a harmful and immature way of satisfying one's wishes and emotions. In popular and pseudo-psychological terminology, neuroses and the symptoms to which they give rise are falsely attributed to a physical source by calling them a "case of nerves," a "nervous breakdown," or a "mental illness." There is, however, nothing organically wrong with the nervous system, nor is the body "ill" in the sense of being invaded by bacteria or of having impaired organ parts. Physical or drug treatment in these cases can do no more than occasionally provide temporary relief and may often cause more harm than good.

The child who learns to use neurotic methods for solving emotional problems will, unfortunately, be handicapped for the rest of his life, for he will not know himself in all of his thoughts and feelings and will be unable adequately to express or to gratify himself. Happiness and joy in living will seem to be just beyond his reach. As an adult he thinks a new job will

bring him that elusive happiness and peace of mind, or he thinks perhaps marriage, a home, children, more money, or a new car will accomplish the miracle. But none of these things outside of him seems to satisfy the longing inside of him.

To illustrate the continuity between childhood and adult neuroses, let us examine the case of Donald B., a twenty-eight-year-old man, who consulted me about his neurotic difficulties. His list of complaints included feelings of inadequacy, lack of confidence, unhappiness, and a poor marital relationship. The youngest in a family of six children, he had had a mother who had been incapable of creating an atmosphere of warmth and security, and as a child he often accused her of not loving him or defiantly denied that she was his mother. His mother's only reply was to administer a severe spanking.

As an adult, Donald was aware only of dislike for his mother, but during his interviews he became aware for the first time of feelings of an opposite quality. "Do you know," he said, with surprise in his voice, "I guess I enjoyed those spankings? They meant my mother was contradicting me, that she really did love me, that she was really my mother. Whenever I wanted to know if she loved me, I managed to make her mad so that she would punish me."

Donald fared no better with his father, who treated him coldly and preferred the older sons. With his brothers Donald felt unable to compete, and wishing to win their good favor, he voluntarily gave up his toys, assumed their duties, or made other kinds of sacrifice.

The seeking of punishment as a sign of love was expressed as well in school behavior. In high school, for example, Donald began each semester with low marks, because he did very little of the assigned work. Part way through the term, the teacher would call him in for a conference and give him a tongue-lashing on the virtues of using one's abilities to the best advantage. Donald agreed with the psychologist that the verbal lashing by the teacher served the same purpose as the physical lashing by his mother: "After the bawling out, I knew the teacher had noticed me. Somehow I felt he liked me or he wouldn't have taken up his time with me. So then I got down to work and ended up receiving an outstanding grade."

This pattern of behavior was repeated in class after class. However, when Donald went to college, no professor con-

sidered him a child who had to be taken in hand and bawled out, and as a result, he was frequently on the point of failing. Only furious last-minute studying pulled him through each final examination. It is noteworthy that Donald's relation to the psychologist followed the same pattern. At the initiation of therapy, Donald was unwilling to talk about his experiences or to express any of his feelings. Progress in therapy became satisfactory only after it was indicated that the interviews could not continue under these conditions, and Donald was surprised to discover that even in his relation to the psychologist, he needed "a bawling out" to help himself. This search for punishment went on in all areas of his life. Usually he was successful in finding it, but repeatedly he made the sad discovery that in adult relations punishment was no sign of love.

With only one semester remaining before graduation, Donald withdrew from college, for the fear of competing with his father and brothers had become a fear of success. After leaving college, Donald, in partnership with his oldest brother, opened an electrical-appliance store; his energetic efforts, coupled with the great demand for household goods after World War II, soon created a profitable enterprise. But Donald's unconscious fears were not to be denied. As he had formerly given up his toys, he now gave up his half of the business to his brother and engaged in other employment.

It might be supposed that Donald would strive to find in marriage the tenderness and affection that had long been denied him. He did so strive, but again unconscious motives from his childhood defeated his intentions, for he married a woman who, though attractive and efficient, was over-controlled, rigid, and completely lacking in warmth. Upon her, Donald focused all of his disappointment and dissatisfaction; frequent and violent quarrels became an almost daily occurrence. Finally, the unhappiness, the desire for harmony, and the longing for love drove him to seek self-understanding through therapy.

After this consideration of the neurotic difficulties of Donald B., we can readily agree with the poet that the child is father to the man. In support of this view, psychologists have supplied evidence from experiments with animals, from

studies of human development, and from cases of children and adults under therapy, to demonstrate that all of the important learning situations, problems, and relationships that determine or influence the formation of the individual's personality can be experienced in approximately *the first six years.* And as we have seen, if the conflicts of this preschool period are handled by the use of repression and not adequately resolved, they then live on to form the structure of all later neurotic ways of life.

The *content* of the adult neurosis may include a dominating boss, business reverses, a nagging wife, overwork, or an alcoholic husband, but the *structure,* the particular form the neurosis assumes, is determined by the unresolved childhood conflicts. This means that the relationships of the adult neurotic are all child-parent relationships. The adult neurotic either seeks love in the same way and with the same dependent expectations as does the child in his relations with his parents, or he insists upon being the parent. None of the relationships of the neurotic are characterized by give-and-take and mutual respect as are those of the mature adult who, while striving for happiness, security, and love, not only satisfies himself, but satisfies also the strivings of the loved one.

By now the reader may feel that we have avoided answering the question posed at the beginning of this article: "Does the teacher cause neurotic conflict?" Instead, we have examined the mental development of the child and some of the significant features of the world in which he lives, but this was done in order to establish what is essential in the creation of neurotic conflict. It was necessary, in turn, to follow through to a conclusion the subsequent development of these childhood conflicts into the neuroses of adulthood. While it is true that no direct answer to our question has yet been supplied, if it has been possible to explain the origin of neurotic conflict without introducing the pupil-teacher relationship, then we indirectly imply that this relationship is of minimal importance as a causative agent. We are, therefore, driven to the conclusion that the teacher does not cause neurotic conflict. The origin of a neurosis is to be found within the family in the mother-child-father triangle.

The teacher, however, cannot be absolved from all participation and responsibility in the neurotic conflicts of the child,

for it was apparent in our earlier case study that in the mind of the child, teachers serve as parent-substitutes. As such they enable the child to seek approval, to delegate authority, and to accept direction in ways similar to those that he has learned from his interaction with his parents. Of course, the child who is not neurotic recognizes that differences between the two situations, home and school, do exist and modifies his behavior accordingly; the neurotic child on the other hand, acts as if they were identical.

The behavior of the neurotic child in home and school relationships, however, need not be syntonic, for the child may make use of the substitute parent in an endeavor to find or to force a new solution to the conflict with the real parent. Consequently, teachers are sometimes startled at being the recipients of much unwarranted love and hate and at being the center of unexpected emotional storms.

How the teacher handles these situations does have bearing upon the intensity of a child's conflict. Afraid of a demanding, impatient mother, a child may have his fear increased by a demanding, impatient teacher, so that he is less able to handle his home conflict. On the other hand, a warm, permissive teacher may supply needed encouragement and support for the child who is torn by emotional conflicts, but is not yet neurotic. This teacher's classroom may serve as a resting place, a place to gather strength for the after-school emotional struggle at home, and the pupil-teacher relationship may give the child the opportunity to perceive that not all women are like his mother. A neurotic solution to his conflict may thus be avoided or the neurotic manifestations may be confined to fewer areas of functioning. It should be noted, however, that once a child settles upon a neurotic way of life, he no longer responds readily to changed environmental conditions and requires psychotherapy to remove the neurosis.

There is one other way in which a teacher may intensify a child's conflict; she may unwittingly strengthen his neurotic strivings by placing too great an emphasis upon compulsive perfection, neatness, and orderliness, and upon non-sensual, non-aggressive behavior. We must not overlook in this instance the fact that the always "good" child may be just as neurotic as the always "bad" child.

Let us go on to answer the second of our original questions: "Does school attendance expose previously hidden immature areas of the personality?" Here it is possible to give an affirmative answer. For example, suppose we have a child who is inwardly struggling with emotional conflicts of paramount importance. Put him in a problem-free environment that makes few demands upon him and he may appear to be functioning adequately. Place this same child in school under the strain of having to cope with a reading primer, other children, or possibly a hostile teacher, and it will be impossible for him to continue fighting against his fears and neurotic wishes. There is then the sudden appearance of tension, temper outbursts, nausea, or other symptoms. It is in cases of this kind that it seems so obvious, and yet so erroneous, to assume that school attendance caused the neurosis, whereas the truth of the matter is that it only exposed a concealed immaturity.

Occasionally, merely the necessity of attending school may act as a precipitant for neurotic behavior because of the meaning that "going to school" may have for the child. For the child disturbed by emotional conflicts, attending school may be a painful, unhappy experience of gigantic magnitude, because it brings about an unwanted separation from Mother, or because it leaves the field clear at home for a preschool-age sibling to take over. School is, therefore, regarded only as a place where pressing personal needs must be ignored or relinquished in order to accomplish unrelated, uninteresting learning tasks. The child then confronts us with refusals to attend school or with vague aches and pains that require his being sent home from school.

If school serves only as a precipitant, as a trigger for an explosive situation whose origin predates school entrance, are parents then to blame? It seems a rather idle pursuit to attempt to fix the *blame* on any one. Neurotic conflicts develop because of the way in which family life is organized in our present-day culture, and because of the attitudes prevailing toward the sexual and aggressive needs of children. They also develop because children are children. They are creatures who can so easily put *two* and *two* together to make

five, and—unfortunately for their parents and educators—sometimes to make *four.*

And now let us close with a few remarks on the prevalence of neurotic conflict, for undoubtedly a suspicion has arisen in the reader's mind that we have included a great many children and adults in our description of neurotic ways of life. This suspicion is well-founded. I am well aware of the strong wish to believe that there are persons who are normal or well-integrated (including ourselves, of course) and only a few who are maladjusted or neurotic. But this belief can hardly be maintained.

All of us have passed through life experiences similar to those we have recounted above. All adults have been children; all parents have been sons and daughters. As a consequence, we all exhibit some neurotic reactions or at least mental scars incurred in resisting them. The seeking of psychological help is not an indication of unusual peculiarity or weakness. The child or adult who welcomes or seeks psychotherapy is not more disturbed than others. He is an individual who has had enough of pain and unhappiness and knows what to do about it.

VOLUNTEERS IN MENTAL HOSPITALS*

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ONE of the most important objectives of the citizens' mental-health movement is the improved care and treatment of the mentally ill. Very few hospitals in the United States meet even the minimum standards set by the American Psychiatric Association. Hospitals are understaffed, and personnel is overworked. Equipment is inadequate. Some categories of hospital staff are grossly underpaid and poorly qualified. For all of these reasons and many others, some therapeutic methods that should be available to all patients can be offered to only a few.

To reach the objective of better care and treatment of the mentally ill, mental-health associations are using many approaches. They are working for more adequate appropriations for state hospitals; for psychiatric services in general hospitals; for improvement of the processes of admission procedures; for the development and expansion of training centers; for more clinics, more research, and so on. It is imperative that we continue our fight through all these avenues and others too numerous to mention here. However, there is another way—a way in which there are vast potentials—a way that has proven its effectiveness in many state, veterans', and military hospitals, but that has been developed in far too few places. I am referring, of course, to a carefully planned, well-coördinated volunteer program.

Such a program may be started as a result either of a request from the hospital or of the community's interest in serving the patient. Whichever actually initiates the program, considerable groundwork must be done. A good volunteer program must be designed to meet hospital needs and

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must be wanted by hospital staff. It can be successful only when personnel understand the value of volunteer services and are willing to coöperate in the training and supervision of the volunteers. In order to reap maximum benefits from a volunteer program, the hospital should have a director of volunteers on its staff, a well-qualified person whose sole responsibility is the coördination of the hospital volunteer program.[1] Such a person should be considered a department head responsible to medical staff and not a member of some other department within the hospital. Then there must also be coördination and coöperation of community groups in the selection of volunteers and in arrangements for meeting other hospital needs.

In both these areas, citizens' mental-health associations have an important rôle. They are in a position to interpret to hospital staff the value of a volunteer program on the one hand and to coördinate community resources on the other. Sometimes they may initiate a demonstration project in which they finance for a certain period of time the employment of a hospital director of volunteers, with the understanding that the hospital will assume responsibility for it at the end of the demonstration time.

What are some of the things volunteers can do? Here are just a few:

Working with individual patients who have had brain surgery and need special and constant attention.

Teaching crafts.

Feeding patients who cannot feed themselves.

Acting as companions for individual patients in "companion therapy."

Taking patients on tours of industries in preparation for their discharge.

Working with shock-therapy patients.

Welcoming new admissions and helping to make them feel "at home."

Carrying on recreational activities of all kinds—games, dancing, etc.

Conducting hobby groups—photography, tumbling, music appreciation, stamp clubs, radio repair, garden clubs, etc.

Taking patients shopping, to community events, on picnics, to play golf, etc.

Participating in psycho-drama.

Assisting the librarian in the main library and taking books to patients on the wards.

[1] A list of suggested qualifications and duties of such a person is available from The National Association for Mental Health.

Giving clerical assistance to hospital staff.
Helping bedridden patients with bedside gardening.
Teaching spelling, arithmetic, etc.
Finding homes in the community for discharged patients or those in the family-care program.
Ward visiting, letter-writing, etc.

It is obvious that such activities can be done well only by volunteers who are carefully selected, trained, assigned, and supervised. Being a volunteer is not something that can be done in a few odd hours when there is nothing more exciting to do. Rather it is the acceptance of a job—a responsibility that requires a definite allotment of time, energy, and intelligence and a real desire to prepare adequately for the job. Volunteers should not be recruited with a "Come on. It won't take much time" approach. Hospitals are run on schedules, and staff must be able to rely on volunteers' being there when they say they will—and even more important, the patients look for volunteers and count on their coming on scheduled days. Psychiatric aides have told me that the physical appearance of their patients has improved 100 per cent since volunteer programs have been inaugurated. Patients whom they couldn't get to wash their faces and comb their hair suddenly became interested in their appearance—slicked their hair, shined their shoes, and scrubbed their hands and faces hours before the volunteers were expected.

Volunteers in mental hospitals are important not just because they are able to supplement what the overworked staff can do (and I use the word "supplement" advisedly because we think of volunteers only in a supplementary rôle and not as replacements for staff). Volunteers are important also because no more valuable aid to therapy exists than those people who go to the hospitals because they want to, who bring the patients a bit of the community and keep them from losing their contact with the world outside. Such service is concrete evidence that friends and neighbors continue to have a genuine interest in and affection for the patients who for too long have been "forgotten citizens."

Dr. Dan Blain, Medical Director of the American Psychiatry Association, has included volunteers in his concept of "the treatment team" and has said:

> "Patients see from day to day not only doctors, nurses, orderlies, technicians, professionals in the field allied to medicine mentioned above, who must perforce under the best circumstances remind a man that he is ill, but the butcher, the baker, the candlestick maker, lawyer, merchant, chief, the champion boxer, local athlete, world-known artists, prominent people, pretty girls, stars of the amusement world. I have been much impressed by local groups under the leadership of capable men and women who have selected good citizens old and young to visit and work with a certain hospital or convalescent home. Volunteers from the local community by and large are of more value than casual visitors, for they come often enough to get acquainted and form a lasting influence."

In this discussion, I have touched only briefly on volunteer recruitment, training, and supervision. I should like to suggest, however, that there are many untapped resources in recruitment and many unexplored areas of volunteer activity. Too often the public concept of a hospital volunteer is a woman—and usually a woman with considerable leisure, some of which can be devoted to hospital service. One volunteer I know is the mother of thirteen children. She gets up at 5:30 in the morning in order to complete her wifely chores in time to report to a nearby hospital for a day of volunteering beginning at 10:00. And there are men volunteers as well as women, from varied walks of life and with quite different backgrounds and experience, who are enriching the lives of mental patients. There are husband-and-wife teams, and there are college students and other young people.

One of the most thrilling programs in volunteer service I know is that of the Ohio-Wesleyan students, under the guidance of the indefatigable Miss Abigail Semans, who every Sunday for the past seven years have traveled ninety miles to spend the day going from one acute ward to another with square dancing and singing. And there have been high-school students who have decorated the recreation hall for dances, have directed visitors on visiting days, and have assisted with the preparation of the patients' newspaper.

There are unlimited activities in which volunteers can participate—particularly when those responsible for the program have imagination and try to utilize available resources.

I remember how the patients looked forward to the day "the pigeon man" came. He was a breeder of homing pigeons and took two pigeons into the ward, told the patients how they were trained, answered their questions, and then released the

pigeons from the ward window. The patients made cigarette wagers on which one would win the race back to the volunteer's home. What discussion and excitement there was until the race results were phoned by the volunteer's wife!

Another volunteer who raised angora rabbits used to take a rabbit into the ward and demonstrate how she made yarn. The friendliness of the volunteer and the charm of the little animal resulted in more pleasure for the patients than most of the "recreational ideas" found in books.

A volunteer from a hospital in Maine wrote me:

> "One morning a parole patient who had been out on the grounds brought us a large bouquet of fragrant mayflowers. We took them over to the building with the bed patients—those helpless with paralysis, arthritis, or heart ailments. One acquires a certain immunity to the tragedies that live within these walls, but the reaction of the men to those simple flowers was overwhelming. It had been ten or fifteen years since some of them had seen or smelled a mayflower and the tears rolled down their cheeks. We left them with the sprays tucked into gnarled, deformed, old hands or pinned to their pillows and went outside before they could see the tears in *our* eyes."

Helping patients who are about to be discharged in their adjustment to community life is another important area in which volunteers can be invaluable. Groups of patients may be taken to a church supper, to a bowling alley for a match with members of a local civic group, to a garden party, to visit various industries to learn of job possibilities, to informal parties in homes in the community. One group of volunteers in Topeka, Kansas, took four or five women patients into their homes and let them bake cookies all afternoon. One woman had been in the hospital twenty-five years and had never seen an electric refrigerator or stove. In another hospital a group of volunteer beauticians spend a day a week at the hospital, so that patients can have their hair done—a volunteer effort that has improved the morale of the entire section, demonstrating that people feel better when they look better.

Once people are told the story of the need—once they are taken into a state hospital to see the desolation, the loneliness, the dreariness—they will respond. Perhaps not every one is suited to actual work with patients—or perhaps he will not want to be—but there are colorful drapes needed to brighten

the wards, and birthday cakes can be made for birthday parties. It is fine to have a big celebration at Christmas with gifts for all, but patients are in the hospitals three hundred and sixty-five days a year, and all year round there are material needs too many to mention here. There is a part every one can play in this important task. Community organizations whose members may not want to do individualized volunteer work can contribute needed supplies and equipment or participate in large recreational events.

In this connection, experience has shown that asking organizations to accept projects instead of "adopting" wards results in the assurance that all patients will be treated alike. Ward "adoption" has sometimes resulted in uneven service to the patients, since organizations or individuals with more resources obviously are in a better position to supply items than the smaller, less heavily endowed groups. The project method also precludes the possibility of possessiveness on the part of the organizations, and also the chance of their selecting only the more responsive patients and neglecting wards where volunteer service is needed equally as much, if not more.

It is considered wise to have the program at the hospital planned with events for wards on a regular schedule, and for organizations to accept projects that are needed in any part of the hospital rather than to become attached to a group of patients in a building or ward.

Another important aspect of the volunteer program is the part it plays in promoting community understanding. Volunteers, because of their activities in the hospitals, are unusually effective interpreters in the community. They can help their neighbors and friends understand that mental illness *is* an illness, that it is not disgraceful, that it requires treatment, that patients do recover, that early discovery and treatment improve chances of recovery, and so on. Volunteers are in a unique position to prod the community conscience so that it will not forget its responsibility to the mental patients—so that it will not forget that more research and trained personnel will increase chances of recovery and the prevention of mental illness.

The potentialities of effective volunteer programs in hospitals, clinics, and state training schools are unlimited, and those of us in the mental-health movement have a unique opportunity to encourage these programs everywhere—as we work toward improving the care and treatment of the mentally ill—through spreading love and service to those who have been forgotten too long.

SESSIONS WITH RELATIVES OF MENTAL-HOSPITAL PATIENTS

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GROUP sessions for relatives of mentally ill patients were started in November, 1953, by the Springfield Mental Hygiene Society and the Jacksonville State Hospital, to meet what seemed to be a real need for some organized effort to help relatives understand the hospitalization of the mentally ill. The approval with which the project has been received would indicate that this need is to some extent being met.

The purpose and aim of the group sessions are limited: to lessen anxiety and promote understanding of mental illness through the reassurance and the feeling of not being alone with the difficult problem that come from group sessions. There was no attempt on the part of the leaders to handle individual problems or to modify basic attitudes or make any personality changes. Such matters, it was felt, were the problems of the staff at the hospital—the ward doctor, the social worker—and did not come within the scope of this project. Questions were answered briefly and in general terms. The leaders waited before answering questions, hoping that these would be answered from the group, and usually they were. Specific questions about hospital routine were of course answered, but not elaborated upon except as the group itself found it necessary to explore them further.

The impetus for this project came after the Springfield Mental Health Center had accepted responsibility for supervising patients from the Springfield area who were leaving Jacksonville State Hospital on conditional discharge, and for making the plans for these discharges. As this responsibility of the clinic became known to people in the community, relatives of patients in the hospital began to inquire by telephone

and in person, about the progress patients were making, and about treatment, visiting hours, and so on at the hospital.

As the inquiries came in, it became apparent to clinic personnel that many of the relatives were anxious about hospital procedures as well as about the actual well-being of the patients. It seemed advisable, therefore, to devise some method for handling these questions and concerns in an organized fashion through the medium of group sessions.

The project was taken up with the Education Committee of the Mental Hygiene Society, a study group that reviews mental-health needs in the community, and the committee recommended to the board that a new committee be appointed to develop a program for relatives of hospitalized patients. The new committee was carefully selected with the aim of making it as representative as possible of the whole community. The chairman is the pastor of a large Protestant church. Other members are the superintendent and the chief social worker of the hospital, the medical director of the mental-health center, the president of the Sangamon County Medical Society, a former judge, a newspaper woman, a Catholic priest, a Negro minister, a businessman, a personnel director, representatives of the C.I.O. and the A.F.L., and the president and two members of the board of directors of the mental-hygiene society. Later the boys' counselor of one of the high schools, the state's attorney, and two doctors who are members of the county commitment board, were added.

Early in the discussion of the committee it became apparent that the relatives of mental patients need help at the time of the patients' commitment and that this is perhaps a crucial point in their lives. It was agreed that, as a community service, a social worker should be assigned to the court. Also, a manual of the rules and regulations of the hospital was distributed to all doctors and clergymen, since they are frequently called upon to interpret hospital procedures to relatives.

Much thought was given to the composition of the group of relatives. Should it be limited to a homogeneous group, such as parents, wives, husbands, relatives of alcoholics, paranoids? It was finally decided that the common denominator was the hospitalization of a relative, and that the time of greatest

anxiety is the period immediately after the initial hospitalization. It was also felt that this is the time when relatives are psychologically most ready to participate in and to gain from such group sessions. After patients have been hospitalized for a certain length of time, the relatives have come to some solution of their problems; and after the patients leave the hospital, there is an individualized service available to them through the clinic. It is immediately after the hospitalization, when the hospital is new and the doctor and social worker are unfamiliar, that there is need for some reaching out to the relative himself, and some attempt to help him through this first difficulty.

In further thinking about the composition of the group, it was felt that if there were one or two persons in the group whose relatives had been hospitalized for a long time, and who had made a good adjustment to the situation, they could give some reassurance to the anxious newcomers. In consultation with hospital personnel, six names were chosen of relatives who might provide the necessary leadership and stability. Of these, two people responded to the invitation to the first meeting. Several others called the mental-health center, wondering why, after all these months or years, Springfield Mental Health Center was suddenly interested in their relatives. With some interpretation, they all agreed that it was a good plan and expressed the feeling that it would have been helpful to them, and that they thought it would be to others.

Because of the time and distance involved—the hospital is thirty-five miles from Springfield—it was decided that the project would start with monthly meetings, to run for an hour or an hour and a half one evening a month. There was no formal structure nor were any time limits imposed. There has never been a time when every one has not come to the meeting within a few minutes of the time set.

The hospital's admissions list for the past six months was scrutinized and twenty-five invitations to the first meeting were sent to the relatives of patients admitted during that period. The invitation was carefully worded, and was cosigned by the president of the Springfield Mental Hygiene Society and the superintendent of the hospital. Despite all the precautions taken in wording the invitation, a number of

people were concerned about it and called up for further explanation.

The educational director of the clinic and the chief social worker of the hospital participated as group leaders in the sessions. No other hospital or clinic personnel were present. Five persons attended the first meeting, which started off practically under its own momentum, everybody contributing rather freely to the discussion.

Present at the first meeting was Mr. F., a young man who had committed his mother to the hospital upon the advice of his physician after she could no longer be cared for either in his home or in a nursing home. Every one in the family had been in agreement about the commitment, Mr. F. was satisfied with the care she was receiving, and it seemed that he had no particular problem. He did not attend the second meeting or the third, but called to ask that the invitation keep coming; it happened to be a hard night for him to come, but he would attend when he could. He did come back to a later meeting.

The second member, Mrs. G., was a woman whose brother had been in the hospital for some twenty years. She has attended the meetings as one of the group leaders and has contributed a good deal in helping other members with the problems that are facing them and at the same time seems to be getting real help for herself.

The third, Miss N., is a woman whose brother has been in and out of the hospital for several years. She, too, has been very helpful to the group and has also been outspoken and quick to defend the hospital when she feels that some one is unjustly critical, and to try to clarify any misunderstandings.

The fourth, Mrs. T., the mother of a twenty-six-year-old boy, is very eager for help and very much concerned about her problems.

The fifth, Mr. A., is a young man, father of two children, who had recently hospitalized his wife against the wishes of all her family.

These five formed the nucleus of the group, and three of them have attended every meeting. Meetings otherwise have been expanded and contracted as other people come and go. These three or four people who form the basic group have

assumed responsibility for welcoming and orienting new members.

Among the problems that were brought out during the meetings were those concerning preventive methods, commitment procedures, and community and particularly family attitudes toward the state hospital.

The concern with preventive methods centered around the need of more facilities for help to children, so that mental illness would not develop.

A great deal of anxiety was expressed by every one about commitment procedures. This paralleled the feelings expressed in the steering committee about these procedures. Several of the group stated that this was one of the most difficult tasks they had ever faced. They did not know what they had signed, and would have been relieved to have had some help in the way of interpretation of several points. As one relative put it, it is a difficult and terrible thing to have to take some one who is dear to you into court and sign papers committing them to a state hospital without even knowing what is going to happen, how long this is for, whether you have done the right thing or the wrong thing. It becomes much more difficult when other members of the family protest.

To this there was a chorus of assent. One relative said, "Yes, that's exactly what my family did. They said, 'Why do you take him down there? He's not really sick. Why don't you keep him home and try this or that?'" Another relative said very firmly: "I stood that talk from my family as long as I could and then I told them I knew the patient best. I had consulted a doctor. We were both sure that this was the thing to do, and they would just have to go along with it." Another said that it took a long time for the family to come around to agreeing with her, but finally they did. Each one seemed to gain some feeling of identification and support from the other members of the group, realizing that he had not been alone in facing this problem.

Some asked why a social worker could not be present to explain the commitment papers. They all agreed that it would have been helpful if they could have talked the thing over with somebody—what it meant, whether it was right, whether it was wrong.

It was interesting to note that this reassurance from other members of the group had some results. At the second meeting, one relative stated that he had told his family about the group, and that his wife's sister had expressed an interest in coming to the meeting. Another relative actually brought one of her in-laws with her, and seemed to gain comfort from having her, too, understand what was happening.

As a facet of the whole anxiety about commitment in the face of protest from other members of the family, there was discussion of private-vs.-state-hospital facilities. One relative said that he could not afford a private hospital—he had his children to think of, too. Whereupon another remarked that state-hospital care was perfectly satisfactory, and that even if she had had money she would not change. They all agreed that it was not only the patient, but every member of the family who had to be considered, so that this relative was reassured about having thought of his children as well as of his wife, and at the same time supported in his selection of the state hospital.

Other matters of concern were brought up—the qualifications of the hospital staff, the visiting hours, the meaning of certain diagnostic terms, and so on. At one meeting an ex-patient who had indicated an interest came to talk with the group. The group immediately began to tell her about their individual problems and to ask for advice on such subjects as "Do you leave the patient at the door and go away as soon as possible, or do you have a long farewell?" "How does the patient feel about being left?" "What do you do when the patient asks you to take him out?"

She was able to tell them that even when she was begging to be taken out of the hospital, she really wanted to remain within the security and sanctuary of its walls. She said that they should not be too much concerned, and should be guided by the opinion of the doctors rather than by the feelings of the patient. She said that it was best to have a quick farewell and that there was no need for worrying, because the patient would actually be happy once he knew he was in the hospital and being taken care of. She reassured them about the care the patients got from the attendants, about the food they ate,

and about a number of other matters that were of great importance to the group.

Another question that came up was how other people in the community felt about the patients, particularly when they were home on a visit; and several members of the group brought up with a great deal of resentment the fact that some of their friends and relatives would not come to visit them, were afraid of the patient. This is one aspect of the total situation that very seldom comes to the attention of the hospital staff when relatives are trying to reassure the doctor that a patient is ready to go home. It often comes to the attention of clinic personnel when the relatives are again trying to reassure the personnel that the patient is well enough to stay out.

In this group they felt free to say that patients have been slighted and that people have shown fear and distrust of them. They all expressed a good deal of interest in learning more about mental illness and spreading information about it to other members of the community. Some one said that not until she herself had a relative in the hospital did she learn that her next-door neighbor had had a similar experience, and that it was out of the feeling of sharing the same problems that she was able to find friends she had not known existed. They were all very much interested in having information about the group written and published, so that other people would understand and perhaps form similar groups.

The first meeting lasted for some two and a half hours. There were several attempts on the part of the group leaders to terminate it, but even after every one was up and ready to go, the members still lingered for more talk. It was also interesting to note that by the end of the second meeting several of the regulars were calling each other by first names, and were beginning to take some interest in welcoming new members into the group.

At the end of the second meeting, one woman sat, very tense and anxious, on the edge of her chair. Finally one of the members who had been present at the first session noticed this and asked her about her son, who was a patient. Then she timidly brought out some pictures. Everybody looked at them and made comments, and there was a visible lessening of her tension. After that she began to participate in the

discussion. This happened over and over again as new members came into the meetings.

At the end of the very first meeting, when they were saying good night to each other, the mother of the young son was able to say to the husband, "Your problem is greater than mine. I hope we can help you."

An evaluation of six meetings does not give too much of a basis for definite conclusion. However, we can make some speculations as to the value of the sessions to the relatives, to the committee, and perhaps to the community.

The group does have a cohesive leadership base in the three or four people who have come regularly. There seems to be a sense of belonging—a unity that comes from having similar problems to face, from being able to share and to achieve some common understanding and to express fears and anxieties, usually hidden. There seems to be more self-confidence, a lessening of the feeling of isolation and uniqueness, and an ability to understand and interpret the hospital and the illness with less defensiveness. These seem to be the tangible gains and these were the goals set up.

We feel, too, that there is the beginning of a better understanding of the patient, more tolerance, more faith in the outcome of the illness, more patience and perhaps less frustration. That the group continues to meet and is able to express a sense of the value of its meetings, seems to be some proof that it has been a gain to these people.

For the committee, there has been a greater awareness of the specific problems that trouble relatives of the mentally ill, and several definite steps have been taken in an attempt to solve these problems. Information about mental illness in the hospital has been circularized through ministers and doctors, and through the committee meetings members of the commission have been made aware of the problems of commitment. There is increased activity toward having a social worker at the court to meet with these relatives.

For the community, there has been increased appreciation of the place of the hospital and the clinic in the total program for mental health, and greater awareness perhaps of the fact that there are groups that are interested in furthering this program.

GREETINGS FROM NORTH AMERICA TO THE FIFTH INTERNATIONAL CONGRESS ON MENTAL HEALTH *

BLANCHE F. ITTLESON

The National Association for Mental Health

THE various governments and the federation have voiced their greetings to the representatives from all parts of the world, to the conference.

However, as the representative of North America, I give you an especially warm welcome and thank you for coming from afar to this significant meeting. I feel very humble and inadequate. Since I am unknown to most of this audience, you will ask why I am here. I cannot answer that question except to say that I am the oldest lay volunteer still active in the field of mental health, after forty years of intensive effort.

My experience in working for improved mental health and mental-health services has been one of deep personal enrichment and satisfaction. We in this part of the world have come to speak of mental health as an interdisciplinary enterprise which cuts across many facets of our common life. There is little we do collectively or individually that does not influence the well-being of our fellow men. Mental health, therefore, in the truest sense, is everybody's business.

Since it is everybody's business, it is of primary importance that we mobilize the interest of as many people as possible—intelligent volunteers who, because of their interest in the cause and dedication to the cause, make possible the programs planned by the professionals. Volunteers, we feel, are of the utmost importance in all fields of social endeavor, but in none more than they are at this time in the field of mental health. They reach the general public and so spread the idea.

As mental health, in its many facets, is comparatively a new social concept, it will take years to reach the understanding

* Delivered at the Fifth International Congress on Mental Health, Toronto, Canada, April 14, 1954.

of the great body of people in any country. Again I repeat, it is of the utmost importance to have as large a body of the public as possible participating. My plea to you, as professionals, is to share widely your problems and your aspirations. Only as you enlist the interest and spiritual energies of the great mass of your population, can you hope to achieve the best results from your efforts. That is good mental health for your people.

I thank you and again a warm welcome to all of you.

BOOK REVIEWS

More About Psychiatry. By Carl Binger, M.D. Chicago: University of Chicago Press, 1949. 201 p.

Dr. Binger has written a book that is outstanding for its wit, charm, and good common sense. It comes at a time when psychiatry is struggling with problems that are a reflection of the general ferment in the field of mental health. A great deal of this conflict is due to the fact that psychiatry has extended itself into areas far afield from its traditional concerns. Because these extensions of psychiatry are more or less recent, many concepts are as yet ill-defined. Furthermore, authorities vary in their ideas as to exactly what boundaries are encompassed in mental health. There are those who believe it to fall exclusively within the province of medicine; others insist that it belongs chiefly to sociology, psychology, and the other social sciences. Questions remain unanswered also regarding the responsibilities of the individual who is rendering service. Is his function chiefly therapeutic, or must he adopt a more positive stand, working in a preventive framework? The vast theoretical and methodological divergences among the various psychiatric, psychological, and case-work groups contribute to the existing confusion.

As more and more professionals working in ancillary fields have come to recognize the need for a psychiatric orientation, additional problems have developed in relation to such areas as the communication of the principles of psychiatry and of mental hygiene; consultative and supervisory procedures in working with professionals, such as teachers, social workers, ministers, lawyers, correctional workers, nurses, and medical practitioners; and the definition of rôle and function among the various professional and lay persons who are involved in educational, counseling, and therapeutic work.

The volume under review focuses on many of these conflicts and problems, bringing to them a fresh and interesting approach. The material consequently deals with a wide variety of topics, the diversity in content and in level being justified by the comprehensive scope of the book.

Of interest to physicians are Chapter I, *The Doctor's Dilemma;* Chapter II, *Psychosomatic Medicine;* Chapter III, *The Mind and the Heart;* Chapter IV, *Psychotherapy in Arterial Hypertension;* and Chapter V, *What Can We Learn From A Medical History?* These present the conflict that confronts the physician in choosing between medicine as a biological science and as a healing art. The basis of sound medicine is described as necessitating a psychosomatic point of

view, which respects the unity of body and mind. The importance of human relations in the practice of medicine is repeatedly accented.

On a different level are Chapter VI, *The Concerns of Psychiatry;* Chapter VII, *Anxiety;* Chapter VIII, *Psychoanalysis;* and Chapter X, *On Choosing a Mate.* For the lay person who seeks an orientation in psychiatry these chapters are a lucid and absorbing exposition of the field.

Professionals who are particularly interested in mental hygiene will be stimulated by Chapter IX, *What Is Mental Health?,* which contains an excellent definition of the goals of mental health. Chapter XI, *Why the Professor Fell Out of Bed,* is a classic exposition of the relation of psychiatry and medicine, which furthermore outlines a positive, preventive mental-health program. Chapter XII. *Medical Information and Misinformation,* discusses problems of communication that confront professionals who attempt to get their ideas over to the public. Chapter XIII, *New Partnerships for Psychiatry,* deals with the theme of preventive psychiatry in terms of the need for professional participation in local, national, and international affairs.

More About Psychiatry is written in a delightful literary style and in itself is an excellent example of effective communication. It is highly recommended to psychiatrists, medical practitioners, psychologists, social workers, teachers, and other professionals who are concerned with the problem of mental health. The few chapters that are intended for the layman seeking information about psychiatry are so well presented that these portions of the book can also be recommended for the general public.

LEWIS R. WOLBERG.

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ENGAGEMENT AND MARRIAGE. By Ernest W. Burgess and Paul Wallin. Chicago: J. B. Lippincott Company, 1953. 819 p.

This book is a notable example of how our scientific knowledge in sociology accumulates. The senior author, Ernest Burgess, in his earlier work with Leonard Cottrell, Jr., *Predicting Success or Failure in Marriage* (1939), investigated factors associated with marital adjustment. Since the information that they obtained on the background of the married couples, as well as on certain other predictive factors, was supplied by the couples after marriage, the question remained as to whether some of these items were influenced by the happiness or unhappiness of the marriage. In part to overcome this objection, the present study was undertaken. In this new study the problem is solved by using data secured from couples before their marriage. The couples were followed for about a decade, from their first dating experiences

in 1936 through from three to five years of marriage in 1946. Such is the patience and steadfastness of purpose with which social science is now being made.

The main hypothesis of the study is that adjustment in marriage can be predicted from data secured during engagement. The problem has two parts, which may be stated as questions. First, are certain data secured from couples before marriage correlated with marital adjustment? The answer is yes. This study confirms most of the findings of the earlier study as to the predictive value of background items, such as that self-rating of childhood happiness as above average is associated with marital success, as is the desire to have children, if shared by the engaged couple. The most important new finding is that success in engagement is predictive of successful marriage. In this phase of the study, questionnaires were used that were filled out by 1,000 engaged couples, one of each having attended college for at least a year and being a resident of metropolitan Chicago.

The second question can be stated thus: Can one forecast during engagement the risk group into which a particular marriage will fall three to five years after marriage? A group of 30 raters, using interview materials secured from 226 engaged couples, assigned ratings to these couples in terms of their probabilities of success in marriage. After marriage, the same couples were tested for marital adjustment. The rating scores and the marital adjustment scores correlated .42 for men and .39 for women, indicating a fair degree of success in forecasting marital adjustment from engagement data.

With improved methods of measurement and the identification of more discriminating factors in marital success, greater predictability of future marital happiness should be possible. Indeed, there are reports from "informed sources" that further advances have been made in forecasting marital success since this book was published. Science marches on.

M. F. NIMKOFF

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PERSONALITY MEASUREMENT. By Leonard W. Ferguson. New York: McGraw-Hill, 1952. 457 p.

The nearly forty tests of personality selected for examination in this text constitute a good representation of the best tests, of the variety of tests, and of some of the more recent developments in ratings and performance tests. The details of test construction, item selection, scoring, standardization, reliabilities, intercorrelations, and validities are presented quite clearly.

The selected tests are categorized under seven types, each of which involves two contrasted approaches. Separate chapters are devoted

to each type and each approach, as follows: vocational-interest tests, empirical and rational approaches; attitude tests, *a priori* and *a posteriori* approaches; personality tests, unidimensional and multidimentional approaches; adjustment tests, diagnostic and prognostic approaches; ratings, nonanalytical and analytical approaches; projective techniques, perceptual and imaginal approaches; and performance tests, observational and experimental approaches. However ingenious these categories may be, they are often based on superficialities. They will surely confuse many students.

Except for the vocational-interest tests, there is little discussion of applications or pitfalls in the interpretation of individual test scores. Indeed, the client, with all of his idiosyncracies, seems to be nonexistent. The text seems to presume an introductory course in tests and measurements, because there is no discussion of the general theory and fundamentals of test construction. It does not seem suitable, however, as an advanced text for majors in clinical, vocational, or business psychology because each of these groups needs a broader and more intensive study of materials especially relevant to their special problems. It may perhaps best serve as a text where advanced courses in these specializations are not offered.

FRANK K. SHUTTLEWORTH

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ADOLESCENCE AND YOUTH. By Paul H. Landis. 2nd edition. New York: McGraw-Hill, 1952. 461 p.

With respect to over-all organization, the second edition of *Adolescence and Youth* has not changed appreciably from the first. A great deal of new material has been included, particularly from research sources, and free use is made of material collected in the author's classes. On might say it is characteristic of the teen-ager to inquire within himself concerning his motives and goals; Professor Landis makes good use of this tendency. As in many textbooks, there is a tendency to quote at length from secondary sources and to reproduce lengthy statistical tables without much attempt to weave these tables or their principal conclusions into the author's own developing argument.

As a text in adolescent development, this book leans heavily upon social theory and sociological sources, as would be expected from the author's professional affiliation. As such, it is an excellent complement to more psychologically oriented texts. The book treats least completely the topic of the biological basis of adolescent growth changes. A good demographic picture of the adolescent portion of our total population is presented, but the discussion of adolescent

personality leaves something to be desired from a psychological viewpoint. On the other hand, the section on attaining moral maturity deals fully and realistically with the problems of parent-child relationships, religion, and behavior breakdown in delinquency. Few modern textbooks on adolescence have attempted to consider the consequences in adolescent behavior of the trend toward permissiveness in the child-handling of the past thirty to fifty years. This book does make such an attempt, and points out the adolescent's need for limits on behavior as well as for freedom.

The sections on "Transition to Marital Adulthood" and "The Struggle for Economic Adulthood" are among the best in the book. Completely documented and excellently presented, the problems pertaining to courtship activities and establishing new families in late adolescence and early-adult life are thoroughly treated. The educator will probably be disappointed in the discussion of the school and education, especially the treatment of the modern school's curriculum in relation to individual differences and needs. While not completely definitive, the discussion does present the scope of the problem and refers to an adequate list of resources for further material. The problem of differential educational opportunity, the country over, is presented more adequately than is the secondary-school curriculum.

The book makes good use of graphic presentations and is highly readable, from a student's point of view. Quotations from adolescent documents make it personal and real. It deserves wide use.

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PRACTICE OF SOCIAL WORKERS IN PSYCHIATRIC HOSPITALS AND CLINICS. By Tessie D. Berkman. New York: American Association of Psychiatric Social Workers, 1953. 158 p.

This book is the report of a study made by Tessie D. Berkman and sponsored by the American Association of Psychiatric Social Workers under a grant from the National Institute of Mental Health. Myron John Rockmore chaired the Research Study Committee of the A.A.P.S.W., which was composed of prominent leaders in the field, and Dr. Helen L. Witmer and Dr. Sophie T. Cambria acted as research consultants.

The study represents the contribution of a large group of psychiatric social workers, clinical directors, and other psychiatrists, who generously provided the extensive data on which Miss Berkman's conclusions are based. The response of 66 per cent of the agencies circulated, which include nearly two thousand psychiatric social workers, is in

itself a tribute to the challenge of the instrument used, the pertinence of the inquiries, and the interest of the profession in supplying the material. The study indicates the differences in setting, breadth of functions, and variety of responsibilities carried by psychiatric social workers, and their versatility in adapting their skills in so wide an area.

Miss Berkman's extensive supervisory experience in family service, in psychiatric hospitals and clinics, in teaching, and in research, adequately prepared her to correlate and evaluate the tremendous mass of material gathered.

In this first extensive, systematic study of psychiatric social workers, Miss Berkman ably reports the answers to three questions asked: "Who are psychiatric social workers?," "Where are they?," and, "What do they do?"; and the implications drawn indicate deep knowledge and understanding of psychiatric hospitals and clinics. At no previous time has the field of psychiatric social work been supplied with such important data on the responsibilities of the workers in their field. The reviewer questions, however, whether the geographic location and relative inaccessibility of the majority of large psychiatric hospitals, their distance from the areas from which they receive patients, and the nature and degree of the patient's psychotic involvement, have received adequate consideration in some of the implications stated. In order to secure accurate material to answer some of the questions raised by Miss Berkman, it would probably have been necessary to structure the instrument differently. It should be noted that one-half of the 974 social workers who gave information were in state hospitals, and one-fourth in the Veterans Administration, and that governmental influences in the returns are very strong. The amount of control exercised by the budget and civil service over the parent institution and social service, together with the legal restrictions, the time element involved, and the medical responsibilities carried by the hospitals, condition the policies under which psychiatric social work must operate.

Budget officials understand the need of ward personnel adequate in number and in training, including such adjunctive services as physiotherapy, dietetics, occupational therapy, and recreation. The nature, functions, and value of social service are not as clearly comprehended by these officials, we believe, as prior to 1951, no allowance for social workers in New York state hospitals was made in relation to the annual number of admissions and the total hospital census. The social services necessary for patients in the hospital were given on time actually allowed by the budget for convalescent patients.

State hospitals, including their personnel departments, usually operate under civil service. Appointments depend on civil-service

lists of applicants available at a given time, and their interest in specific hospital appointments. This limits the choice of the supervisor of social work in recommending individuals to the director—the psychiatrist—who does the appointing. It is much easier for a clinic psychiatrist not under civil-service regulation to select and appoint, particularly if there are only one or two workers on the clinic staff. In a private clinic, there is less pressure in regard to intake and size of case loads, with more benign illnesses under treatment and less fluctuation in the patients' condition. Consequently, the need to act promptly to protect the patient or the community is less frequent and the psychiatric social worker has more freedom to act independently.

The community has in large measure delegated the safety of the patient and of the community to psychiatry as a branch of medicine. Certain aspects of this responsibility, arising from the patient's needs, dictate to a large extent the intake and release policy for patients, and this cannot be assigned to non-medical staff. The number of social workers in proportion to the number of psychiatrists affects the division of responsibility and duties in many cases, since preference is always given to those most urgent. Often the decision is based on who can best do a particular job in an institution. The area in which the patient is located, his admission to a receiving hospital in another city or town before his certification or commitment to a state hospital, make it generally impossible for a state-hospital social worker to know who is being admitted until the individual actually reaches the hospital.

State schools ordinarily have waiting lists, and although patients may be received as emergencies, the safety of the child or the adult entering a state school, and that of the community, is not as urgent a matter as in the admission of psychotic individuals to mental hospitals. Weeks may intervene between the application for and the actual admission of an individual to a state school, thus permitting interviews with the family before the patient enters.

The time involved between the patient's admission to the hospital and his first interview with the social worker is related to the variety of mental and physical examinations, special tests, and treatment procedures that are initiated on the day of his arrival and that in some situations preclude the possibility of seeing the patient until he has been in the hospital from three days to a week. Here, again, the medical responsibility is primarily to discover the degree of the patient's illness and to initiate appropriate treatment at once.

The profound illness of the patient and his separation from the community largely govern the choice of social service working with relatives when the patient is in the hospital and the changing of focus to the patient during the period of his convalescence in the com-

munity. The very high patient-census of many psychiatric hospitals, the regular admission of large groups of patients regardless of bed capacity, together with the very serious degree of the patient's illness, are related to the nature and place of the worker's activity. The patient's need of continuous care, and his incapacity to handle many personal matters that are adequately managed by patients attending psychiatric clinics, also account for some of the differences noted by Miss Berkman in various clinical settings.

Geographical districting as a method of case assignment is related to the very large areas from which the majority of state hospitals receive patients, and the consequent need to save traveling time and expense. A clinic usually serves patients in its immediate vicinity and those from other locations who are able to come to the clinic, making assignment of cases based on the skill of the worker practical in the latter setting.

The lack of a sufficient number of trained psychiatric social workers in the total social-work field, and the limitation of choice placed upon the hospital by the factors noted above, add to the problem of securing adequate staff. When it became possible, in 1944, for psychiatric social workers in many New York state hospitals to live in the hospital's reception area in which they were assigned for field work, rather than in the state hospital, the choice of workers available for appointment was markedly increased.

The job of recruiting a very large number of additional students and psychiatric-social-work personnel is a challenge not only to the schools of social work, but to each member of the professional organizations and social agencies that are interested in developing standards and training or employing psychiatric social workers.

The possibility of sending a copy of Miss Berkman's report to all directors and supervisors of social work participating in the study, and requesting their comments within a specific period of time, is raised. The correlation of such replies would expedite plans for a solution of some of the problems raised by Miss Berkman. As emphasized by Miss Lay, professional education needs such material from the field as well as through committee work, to implement and improve training facilities.

Miss Berkman's recent appointment as associate professor of New York University School of Social Work gives her a unique opportunity to apply her extensive knowledge in preparing students to meet the existing job needs. The field of psychiatric social work is greatly indebted to the National Mental Health Commission, to the A.A.P. S.W., to all who contributed to this study, and particularly to Miss Berkman for a highly valuable and unusually interesting commentary

on the current situation. The challenge is given to all psychiatric social workers in clinical settings to use advantageously the material so objectively presented.

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THE FOURTH MENTAL MEASUREMENTS YEARBOOK. By Oscar Krisen Buros. Highland Park, New Jersey: Gryphon Press, 1953. 1,163 p.

Those who use educational, vocational, or psychological tests will find this book an indispensable tool. It lists 793 tests, with complete details concerning intended subjects, forms, hand and machine scoring, group and individual testing, prices, when copyrighted, and by whom published. More than half of these tests are critically reviewed. The reviews are followed by extensive bibliographies, totaling 4,417 references. The material is new, covering the years 1948 through 1951. All of this is thoroughly cross-indexed.

The heart of the matter is the 596 reviews especially prepared for this volume by some 306 individuals, each chosen for his competence. Uniformly, these reviews are clear and evaluative. Often they are highly critical. They are condensed, but long enough to be adequate. They will prove rewarding reading even for the experts. It is clear that reviews of previous yearbooks and of the present one have exerted and will continue to exert a powerful influence on test authors and publishers to improve their products. The volume is a most important contribution.

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MANIC-DEPRESSIVE DISEASE. By John D. Campbell, M.D. Philadelphia: J. B. Lippincott Company, 1953. 384 p.

This book is avowedly an effort to bring up to date the Kraepelinian attitude toward manic-depressive psychosis as a disease entity strictly based on physiologic disturbances in which the mental symptoms are quite secondary. The author concludes that Kraepelin's description of manic-depressive illness still stands the test of time, but it needs the clarification that he offers in the catalogue of the autonomic disturbances that accompany it—or, in fact, are thought to be basic in it—and in a description of the milder states and their differential diagnosis from a number of physical illnesses. Furthermore, he considers the social complications of the illness and the occurrence of the illness in children.

The author makes no effort to dissemble his bias for an exclusive physiologic orientation regarding the subject, and he considers that the psychoanalytic and, in general, psychologic investigations in the field over the last fifty years have done the study of manic-depressive psychosis a disservice. He rejoices in the "return" of modern psychiatric interest to strictly physiologic method and physiologic theory.

The material is based on 522 cases observed personally by the author with considerable investigation into the hospital records, study of family collaterals, and follow-up work. He discusses the cycloid personality, and relies heavily on this pre-psychotic aspect for the diagnosis in several difficult cases. I gather that he would consider his description of the autonomic disturbances in the illness of fundamental importance. Yet these autonomic disturbances are so general and so varied that it would be impossible to make a diagnosis of manic-depressive illness on the basis of these alone; and further recourse must be had to the actual emotional state, together with the more specifically mental symptoms, the last-named of which he would consider as strictly secondary.

As might be supposed from what has been stated so far, the author places little significance on life-experience factors as causative agents in this illness. If I understand him correctly, he leans heavily toward an explanation involving constitution and heredity, with a peculiar disability of the autonomic nervous system, and the diencephalic mechanisms finally being at fault. He reports several cases of manic-depressive psychosis in children—one in a child of six. This last case is especially interesting. The child was clearly deeply involved with a sense of guilt and estrangement from her usual way of living. The case is interesting because teaching in the past has stressed that manic-depressive illness is a disease essentially of mature life, and its manifestation in children is to be taken with some reservations.

He devotes separate chapters to the social maladjustments, and homicide and suicide in manic-depressive psychosis. He treats also of the matter of prevention of manic-depressive psychosis, and makes the astonishing statement that this prevention is "constantly within the power of the general physician, internist, surgeon, obstetrician or psychiatrist if the physician is aware of the cyclothymic personalities among his patients." He prescribes for such individuals an increase in the time spent in relaxing and in sleep, and hints that failure to heed this advice leads to "nervous exhaustion, inviting an imbalance in sympathetic-parasympathetic control, which may result in a depressive or manic reaction." He notes that surgical procedures should be carried out with caution in known cyclothymic individuals. He recommends "preoperative blood transfusion, massive doses of thiamine

plus nicotinamide, proper sedation without too many opiates," to prevent a psychosis in a known cyclothymic patient.

For treatment of the illness proper he stresses the need for rest and sedation, prohibits the use of the amphetamines, relies heavily on electro-shock in the more severe cases, and even frontal-lobe surgery. The psychotherapy consists, I gather, in direct counsel about rest, relaxation, and persuasion with reiteration of the favorable outcome.

The author is on very shaky ground indeed when he attempts a physiologic explanation of the effects of electro-shock. The account, admittedly rather sketchy, invokes various hormonal effects as a consequence of electro-shock with the possibility that increased adrenal function is finally the causative agent. It may very well be that experience will prove this to have some foundation, but as the material is presented here this is a very tenuous effort to bolster a theory tenuous in the first place. It can very well turn out to be, as far as we know now, that electro-shock does not act in any set way on all patients. This is no proper place to go into the theories pro and con about the effect of electro-shock, but the presentation of the material of this book would lead the uncritical reader to the idea that modern research was on the verge of establishing the actual mechanism of the workings of electro-shock and, by an extension of reasoning, of the causation of manic-depressive illness itself. I doubt that there will be very many readers of this book so naïve—at least I hope not.

This is a disappointing book to this reviewer. It is polemically written and fails to make a case despite the excellent descriptions of the case material. There is plenty to be discovered about the cause and proper treatment of manic-depressive illness, and the physiologic aspects need constant effort at understanding. In this reviewer's experience, despite the very real help given by electro-shock and sub-insulin coma methods, the treatment of manic-depressive illness in no wise has reduced itself to a routine. I know of no kind of problem in which there is a greater need for individual study and treatment. The Kraepelinian view that such patients commonly get well if they are protected against self-destruction still holds true, but this truism should not encourage us to go no further in the study of the patient's distresses and our means of alleviating them. In this matter psychotherapy can play a very important part. It commonly is true that during the active illness, psychotherapy reduces itself to reassurance concerning the outcome, encouragement to the best performance possible, and cautious probing into dynamic factors. But I cannot subscribe to the author's impressions that the treatment of the personality after the illness reduces itself to a regimentation of the patient's life in the interests of increasing relaxation and sleep and recreation as a kind of propitiatory gesture toward the ever-present hazard of the

recurrence of illness. Those psychologic investigations going back to childhood, at which he looks askance, actually offer our best opportunity for the development of that change in attitude necessary to a more balanced emotional well-being. In short, this book would have been vastly more valuable if the author had been more judicial and had presented in a more extensive way the psychologic contributions toward the understanding of this illness. He makes no reference whatever, for instance, to Johannes Lange's classification of the affective disturbances and particularly to that category of psychogenically induced endogenous depression. This I believe has been a very valuable concept in the understanding of this illness, and a study of the psychogenic inducing factors is just as important as study of the endogenous aspects of the illness.

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PERSONALITY DEVELOPMENT IN ADOLESCENT GIRLS. By L. K. Frank and others. (Monographs of the Society for Research in Child Development, Vol. XVI, 1951.) Yellow Springs, Ohio: The Antioch Press, 1953. 316 p.

This monograph reports one of the first comprehensive efforts to study personality by means of a variety of projective instruments and to validate these instruments by cross-checking results. Five techniques were used—the Rorschach, the thematic-apperception test, figure-drawing analysis, the Horn-Hellersberg test, and graphological analysis. The population consisted of 300 girls, 100 in each of three categories—pre-puberal, puberal, and adolescent. Although the socio-economic background of these girls is quite fully described, no attempt is made to equate the groups with respect to family status, intelligence, education, or other factors. The groups quite naturally differ with respect to average age.

The study makes several assumptions: that projective techniques will elicit materials that subjects will not or cannot put into words about themselves; that every child in the adolescent years faces a series of inescapable adjustment demands and life tasks, and that some youth meet these more successfully than others; that adolescence represents a social-cultural as well as a biological transition, and that aspects of adolescent personality development are much influenced by peer-group demands and authority relationships with elders.

Many readers will be disappointed that the group Rorschach rather than the individually administered test was used. In the analysis of Rorschach results, particular attention is paid to the results that can be construed as revealing disturbances peculiar to the adolescent

transitional period. The thematic-apperception test included a number of new or different pictures, and this chapter frankly purports to be interpretative and qualitative, with no claim that conclusions are "proved." Ross Harrison uses his own method of interpretation and avoids any statistical notations, even in the form of simple percentages. He does make free use of quotations from protocols. Like the Rorschach, the thematic pictures were administered to the subjects in groups. Analysis of human-figure drawings, likewise obtained in a group setting, is presented by Karen Machover, whose chapter constitutes one of the first published accounts of her method with extensive statistical detail. Results of a post-drawing interrogation, conducted in the form of a written paragraph interpreting the figure and supplemented by a brief questionnaire, are drawn on heavily for interpretation.

The authors are to be complimented for taking the pains and the space to publish extensive tables in Machover's chapter. This is one of the first papers on figure drawing to present documentation. It is, therefore, possible to contrast and compare descriptive statements made in the text with data presented in the tables. This statement appears (p. 90): "Forced restraint of body impulses may be indicated by a tight waistline, a common feature in drawings of our group." How common is "common"? The tables indicate percentages in different school groups, regardless of age, ranging from 4 to 29, with a median value of 15. Referring to "outgoing and dependency qualities" the author states (p. 100) that "consistent with her relative level of immaturity, the pre-puberal girl stands out in these areas." Of 21 items mentioned as denoting outgoing and dependency qualities, only seven or eight at the most show percentage differences among the three groups probably sufficient to satisfy a statistical criterion of significance, and a few of these favor the puberal and adolescent groups rather than the pre-puberal group! In contrast, in the matter of items denoting interest in sexual characteristics and boy interest, the statement is made (p. 100) that "the pre-puberal gives least notice to these factors." Of the percentages given for the 21 items in this category, the median percentages for the pre-puberal and puberal groups are identical—23, while that for the post-puberal group is 12.

These citations are made not out of any desire to find picayune errors in a particular chapter, but to illustrate the possibility of subjective error in interpretations that are not adequately based on rigorous quantitative procedures that count all the cases. This common fallacy in human thinking is particularly a hazard in qualitative, impressionistic analyses, and great care must be taken lest preconceived "theory" lead one astray. After all, as has been pointed out before, projection can cut two ways.

The chapter on the Horn-Hellersberg test, written by Elisabeth Hellersberg, presents much detail that will be of assistance to the reader who wishes to make his own analyses. Reference is necessary, however, to the author's other publications in order to understand the scoring points recorded in the tables. The chapter on graphology leans most heavily on verbal descriptions, and gives no actual illustrations to indicate precisely what is called an "area of zoning" or "insecurity of stroke" or a "free loop."

Careful reading of the individual chapters and of the interpretative summaries at the end reveals a number of distressing inconsistencies in generalizations. For example, at one point the prepubescent girls are considered to be mainly outgoing and free; at another point they are considered to be principally dominated by introversive tendencies. In a sense, it is to the authors' credit that they have suffered their disagreements to stand, when judgments were arrived at independently. It would have been easy to "discuss away" the inconsistencies.

Perhaps more distressing is the failure to come to grips with a definition of what constitutes adjustment. The materials here are found to indicate that the majority of the girls are tense, unhappy, and disturbed. At this point the authors recognize that something may be wrong. They recognize that in many definitions abnormality gets its meaning by contrast with the generality or commonality of experience. In such a definition the commonality of experience is not considered abnormal, but only the extreme deviations from the more characteristic pattern. Which, then, holds—the absolute definition of adjustment, or the relative definition?

The data of this study suggest that the great majority of adolescent girls suffer considerable maladjustment. "For the whole group of 300 girls the study gives evidence of more frequent and more severe emotional disturbances in these girls than was anticipated, especially in the area of interpersonal relations which apparently give rise to an intensely introversive pattern, of preoccupation of personal perplexities, feelings and fantasies" (p. 194). Again, (p. 194) "there is also evidence of serious personality distortions, of severe trauma (this is probably sexual) among the girls of the lower socio-economic groups." And again, (p. 194) "among the pre-puberal and puberal girls the 'frightening mask' in all its variations is a popular response to Rorschach cards, indicative of the pervasive fear of life among these girls."

Workers intimately acquainted with large numbers of young girls often remark on the happy, healthy attitudes of to-day's adolescent populations. Assuming that both sets of workers are correct in their observations, is it possible that the authors of this volume did by some mischance get an exceedingly deviant group of girls? If so, their

study is particularly unfortunate as a basis for generalization. If they did obtain a reasonably representative sample of young adolescent girls, then perhaps their interpretations, or their reference points, may be questioned. From a straight analytic-research point of view, far more work must be done on the psychological correlates of clinical signs before we can place easy confidence in a one-to-one relationship between particular signs and underlying personality trends.

This, then, is our impression of the volume. It is a valiant and indeed a most significant attempt, but unfortunately it is completely self-contained. At no point were bench marks in the form of other techniques of psychological analysis used, such as psychometric tests or observations of personality made by teachers or other non-clinical workers. In each chapter the author had his or her opportunity to explore his own scheme of thinking, often quite self-contained with respect to the data collected on this group of girls. Much science has started this way, but scientific work eventually manages to get out of these self-contained circles. (Though some psychologists deny that it is possible, the "external" criterion of validity is still a potent concept.) It is not too much to expect that projective methods will eventually do the same. Indeed, results of projective techniques must be subject to agreement among independent observers if they are to be considered scientific.

DALE B. HARRIS
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PSYCHOTHERAPY: THEORY AND RESEARCH. By O. Hobart Mowrer and twenty-one contributors. New York: The Ronald Press Company, 1953. 700 p.

This is a work of major proportions. It is a source book that will be essential reading for all graduate students in clinical psychology. It is not a book to be read continuously, as a whole.

In his preface, Professor Mowrer expresses what amounts to a declaration of independence for psychologists in the field of psychotherapy. "Who other than psychologists might be properly expected to concern themselves centrally with *psycho*pathology and *psycho*therapy!" All but two of the contributors have Ph.D. degrees, and there is not an M.D. in the entire list. It seems to the reviewer that the book might have been titled more properly, à la J. B. Watson, *Psychotherapy From the Standpoint of Some Psychologists.*

A very high level of scholarship and of sophistication characterizes this volume and demonstrates the rapid and solid advances that psychology as a science is making in the present period. Eight chapters are assigned to theoretical considerations and eleven to research

methods and results. Professor Mowrer himself has contributed two chapters on theory and two on research. He is senior author of two research chapters and junior author of another. The University of Illinois and the University of Chicago are most heavily represented among the other contributors.

The primary orientation of this collection of papers is expressed in the introduction: "One thing is already sufficiently clear: personality disorders, in the great majority of cases, have no demonstrable physical basis and no proved physical treatment. The problem, from the standpoint of both causation and correction, is basically psychological or psychosocial and revolves around the phenomenon of *learning.*"

Rollo May, already well known for his original work, *The Meaning of Anxiety,* has made a further contribution in his present chapter, *Historical and Philosophical Presuppositions for Understanding Therapy.*

The ubiquitous Carl R. Rogers presents in his chapter the notion that psychotherapy is a process by which the individual "becomes his organism—without self-deception, without distortion." He thereby gives us a succinct way of defining mental health. Rogers was a genuine pioneer in the verbatim recording of interview content and well deserves credit for directly facing the material itself in the systematic study of the therapeutic process. In the present context, however, and after the publication of so much interview data, it seems that the exact items could be taken for granted. The reader could easily accept a condensed report of the material as filtered through the mind of Dr. Rogers.

Psychotherapy and its public-health implications are discussed by Joseph M. Bobbitt and John A. Clausen, of the National Institute of Mental Health. Their analysis of the problems of developing means for improving the mental health of the public is excellent and authoritative. It should reach a wider audience than that for which the book as a whole is intended.

The ten chapters on research methods and results are of an extremely technical and detailed nature. There is perhaps more emphasis on methods than on results. In a still-infant science such a state of affairs is appropriate.

It seems somewhat unfortunate that so much space was allotted to methods of inter- and intra-individual statistics. This is especially so since Cronbach felt obliged to append a footnote acknowledging the recent recognition of the severe limitations of such methods.

Louis L. McQuitty's chapter, *A Statistical Method for Studying Personality Integration,* is most stimulating. In his own words, "From the point of view of the theoretical position just outlined, the

most healthy-minded individual is one whose ideational life is composed of but one self-descriptive factor; he is one who has achieved an interrelationship among all his ideas about himself." It is to be hoped that Professor McQuitty's work will continue to prosper, since it has highly significant practical and theoretical implications.

The remarks in this review are intended to be a guide to the prospective reader. In such an extensive work there are obviously a multitude of points and ideas that might have been discussed further. A genuinely comprehensive review could best be made by multiple reviewers.

DOROTHY CLIFTON CONRAD
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THE WORK OF THE COUNSELOR. By Leona E. Tyler. New York: Appleton-Century-Crofts, 1953. 323 p.

This book must be evaluated in the light of the purpose for which it was intended and as a text for a first course in counseling procedures. Although other readers will find it useful, it is intended primarily for those interested in college and high-school counseling. Furthermore, it is intended for the general counselor who attempts to help students with a variety of problems, rather than for a specialist in vocational guidance, marriage counseling, psychotherapy, and so on. Still further, it stresses the common principles that underlie many types of counseling and avoids proclamations of loyalty to any "school of counseling."

With these characteristics, it constitutes a rather unique contribution to the field and should be welcomed by those who have been waiting for such a textbook for use in beginning courses on counseling procedures. Previous contributions have been concerned with a particular area of counseling (vocational, personality, etc.), with a particular "school of counseling" (client-centered, eclectic, etc.), or with the entire student-personnel program, with counseling forming only one part.

Dr. Tyler sets the stage nicely, by beginning with a discussion of the counselor's function in modern society. She then moves rapidly to a discussion of the major aspects of the work of the counselor, through chapters on the interview, the use of records, the problem of diagnosis, the uses of tests and their integration with the counseling process, the use of occupational information, psychotherapy, and decision-making interviews. The book concludes with discussions of the place of counseling in the total personnel program, selection and training, and the evaluation of counseling.

The author does a particularly good job in helping the would-be counselor understand the difference between the rôle of the counselor

and other student-personnel rôles. If accepted, Dr. Tyler's differentiations would help eliminate much of the friction that exists among the various types of personnel worker. She also offers the young counselor some good suggestions about how to maintain the counselor rôle and avoid "traps" that limit his effectiveness.

In the process of reading this book, the reader may at times become annoyed in the effort to discover a dominant theme or point of view. Such a dominant theme actually does exist, however. It is perhaps most clearly stated in the closing paragraph, when Dr. Tyler concludes that the important concepts in counseling have to do with self-understanding and responsible decision-making rather than with diagnosis, prediction, and treatment of problems; and that it is quite possible for good counseling to exist under quite different circumstances and philosophies. Although such a point of view is considered sound by this reviewer, and certainly makes the book useful to a larger number of people, at the same time it probably results in what may be the book's most serious defect—an overcautious approach which may encourage mediocrity of performance. This does not mean that an emotional appeal as to the glories of the work of the counselor is needed. Certainly, however, a greater sense of the "high adventure" of the job of the counselor might have pervaded the book. There is too much of an assumption that the counselor must accept what is known and more or less follow it as standard operating procedure. Counseling is not pictured as the everlasting discovery, learning, and creative process that it actually is. Too little is said about how the counselor may continue to grow on his own responsibility.

These deficiencies, however, are somewhat offset by the fact that Dr. Tyler presses for the point of view that "counseling is more than remedial work, more than therapy, more than an aid in the making of decisions." According to her point of view, counseling "represents a way in which people can work together to understand our common human life and at the same time try to enrich it."

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ADJUSTMENT TO PHYSICAL HANDICAP AND ILLNESS: A SURVEY OF THE SOCIAL PSYCHOLOGY OF PHYSIQUE AND DISABILITY. By Roger G. Barker, in collaboration with Beatrice A. Wright, Lee Myerson, and Mollie R. Gonick. (Bulletin No. 55, revised.) New York: Social Science Research Council, 1953. 440 p.

This is a truly remarkable book. One puts it down with a sense of deep indebtedness to Roger Barker and his colleagues, to the associa-

tions that have sponsored their work, and to our total way of life that makes possible the kind of rational and catholic approach that the authors of this book take.

For those who work with the ill and handicapped, the book is a lucidly written compendium of existing knowledge on the relationships between bodily stress and socio-psychological forces. For those who, like Dr. Barker, are concerned with the extension of knowledge, the book is a gold mine of theoretical formulations and hypotheses. For the physician, the administrator of medical facilities, and the many persons ancillary to medicine, for the social worker, the psychologist, the teacher of the handicapped, and the vocational counselor —for every one who works with people (all of whom may experience acute illness), this book presents a critical review of research and expert opinion, of insights from literature and case studies, as well as of the folklore that surrounds such illness as tuberculosis.

The book consists of eight chapters and an end-of-tome bibliography of from almost 100 to close to 200 items for each chapter. Following an introductory chapter—in which the authors remind us that "a person's body is an object in his life situation with which he behaves as he does with other behavior objects" (p. 7)—are chapters on "somatopsychological" aspects of physical size, strength, and attractiveness, on crippling, on the psychology of the tubercular, on impaired hearing, on impaired vision, on the social psychology of acute illness, and finally on employment of the disabled. Each chapter is followed by analytic summaries of individual research reports.

As the revision of an earlier edition, this book is part of an ongoing inquiry and so presents no final answers. It is written in the very best scholarly tradition—clearly, logically, questioningly, thoroughly. While one of its aims is to develop conceptualizations of situations involving illness and handicap, the better to understand them, it includes objective consideration of other available formulations—medical, psychological, psychoanalytic, sociological, psychiatric. For example, in the chapter on orthopedic impairments, after thoroughly reviewing research in this area that bears on the adjustment of crippled persons, attitudes toward their disabilities, and theories on "somatopsychological effects," the authors remark:

> ". . . we do not consider it desirable to attempt further evaluation or synthesis of the theories that have been presented. In the present stage of knowledge concerning the somatopsychological effects of crippling, it seems advantageous to have a variety of theories of the sort that stimulates further inquiry. It is in this spirit that we have contributed our own theoretical views in this publication" (p. 93).

The concepts that the authors themselves advance are based on Kurt Lewin's field theory. If previous experience with the writings

of topological psychologists has been troublesome, be assured that these authors respect the reader's concern. All "spatial representations" are buried in footnotes, so as not to impede the reader's following the text. Moreover, the concepts of "egocentricity" and of "overlapping situations" and "new situations" in which the ill and handicapped persons live are presented simply and prove illuminating, in, for example, analyses of the "psychology of the sanatorium situation" of the tubercular patient and the psychology of situations in which the acutely ill find themselves; in diagnostic and treatment situations; in hospitals and doctor-patient relations; in convalescence and reconditioning programs.

Repeatedly, through the eyes of social psychologists, this book offers new perspectives on the ill and the physically deviate, on medical practice and the problems of productive work for such persons. Sociology, through Talcott Parsons and his colleagues, and anthropology, through George M. Foster and others, have recently been making similar contributions to our understanding of what formerly was considered the concern only of the physician. Such work reinforces one's faith in the capacities of the human intellect in our society gradually to clarify and to deal with the many problems that beset us. Socio-psychological aspects of illness and physical incapacity, high on the list, are likely to become less mysterious and more manageable problems through the continuing efforts of people like Dr. Barker and his collaborators.

HENRY S. MAAS

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CONFERENCES ON DRUG ADDICTION AMONG ADOLESCENTS. By the Committee on Public Health Relations, New York Academy of Medicine. New York: Blakiston and Company, 1953. 320 p.

During the height of the teen-age "epidemic" of drug addiction in 1951 and 1952, the New York Academy of Medicine, assisted by the Josiah Macy, Jr. Foundation, held two conferences on drug addiction. The aim of these conferences was to bring together experts from many disciplines concerned with the problem of drug addiction, for the purpose of pooling and exchanging existing knowledge and experience. It was hoped that in this way a broader-based and more concerted attack on the problem of adolescent addiction could be evolved. Represented were physicians, psychiatrists, public-health experts, pharmacologists, sociologists, educators, social workers, legislators, jurists, and law-enforcement and probation officers. This book is the verbatim transcript of the proceedings of these conferences.

The value of such face-to-face interdisciplinary conferences for the

participants involved is undoubtedly high. They constitute an important educational experience which helps the expert in a particular field to view the larger problem in broader perspective. Considerations such as these, however, are outside the province of the book reviewer, who is called upon to judge whether and to what extent verbatim records of such conferences are useful to professional or lay readers. A reader has different expectations from and uses for a book than a participant or spectator in a conference. He is primarily interested in a comprehensive, authoritative, well-organized, and highly documented volume to which he can turn for guidance in a given field of knowledge.

The need for a new book on drug addiction based on a multi-disciplinary approach is especially great since there is at present no satisfactory treatise in the English language that includes discussions of the pharmacological, psychological, social, and legal aspects of the problem within a single volume. The unfortunate consequences of this lack were clearly apparent in the flood of misinformation that descended upon the American public when drug addiction was "front-page" news in 1951. Wikler's *Opiate Addiction* is an admirable summary of the pertinent neurophysiological and pharmacological literature, but its scope is obviously limited. Lindesmith's similarly entitled treatise considers social and psychological factors involved in addiction to drugs. It also illustrates the pitfalls awaiting a sociologist who relies exclusively on interview data with drug addicts when he has little independent knowledge of the pharmacology and neurophysiology of drug addiction and no experience with the clinical course of drug addiction. The recent volume, *Narcotics, U.S.A.*, edited by Paul Weston, suffers from the heterogeneity of the contributors' viewpoints and from lack of real expertness in the neuropharmacology and psychology of addiction.

Conferences on Drug Addiction includes an extremely wide miscellany both of interesting and of tediously dull material on drug addiction. Every conceivable aspect of the subject is eventually covered, but in a thoroughly disorganized, undocumented, and non-authoritative fashion. No one aspect of the subject, with the exception of Stanley Bigman's excellent discussion of "psychological, cultural, and sociological factors," is treated adequately. The volume contains a curious mixture of reasonably well-informed opinion presented in an "off-the-cuff" and fragmentary fashion, loose and poorly formulated speculation, and long-winded reminiscences. A disproportionate amount of attention is given to technical matters of court procedure in New York City and to administrative details relating to the New York City-State treatment center for adolescent addicts on North Brother Island. Typical of the many loose and inaccurate statements

found in the book is the astounding reference to alcohol and marijuana as "stimulants" (p. 10) by the expert discussing "recognition and classification" of drug addicts.

One of the most lamentable features of the book is that no attempt has been made to bring together in some orderly arrangement materials of a related nature. Since chronological order of statement is the only basis of organization, the treatment of a given topic is confusedly scattered throughout the entire volume. In the absence of chapters, headings, and subheadings the only guide to content is the index. Many discussions are circular, repetitious, and irrelevant. The welter of conflicting and contradictory opinion (much of it unnecessary) leaves the reader confused and bewildered.

These deficiencies are both understandable and inevitable in an informal conference with only few and brief prepared addresses and much extemporaneous and informal discussion. But why publish verbatim and unedited proceedings? Of what value is offhand and unsubstantiated opinion to a serious reader who is not a specialist in this field? What criteria can he use to distinguish between fact and opinion, or between informed and casual opinion? Is it worth while owning any reference work that cannot be consulted with facility or confidence?

The New York Academy of Medicine has missed a splendid opportunity to meet a genuine and long-felt need of many serious and interested persons in the fields of mental and social hygiene for an authoritative interdisciplinary textbook or symposium on drug addiction. Unfortunately the same vehicle cannot at the same time satisfy both this need and the need for informal interpersonal communication among experts from diverse disciplines confronted with a common problem. As a result, the crying need still exists, and another inadequate book is available to add more confusion to a field already rife with loose opinion.

DAVID P. AUSUBEL

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ANNUAL REVIEW OF PSYCHOLOGY. Vol. 4. Edited by Calvin P. Stone and Donald W. Taylor. Stanford, California: Annual Reviews Inc., 1953. 485 p.

This is the fourth annual review of psychology under the editorship of Calvin P. Stone and Donald W. Taylor. It follows the pattern of the previous volumes in presenting a critical evaluation of the past year's psychological literature. Nineteen fields of psychology are comprehensively reviewed by eminent specialists, who provide the

reader with research findings and suggestions for future investigations within the area of their special competence.

The artificialty of dividing the general field of psychology into separate chapter headings is recognized by the editors, and they present a plan for unifying the subject matter of the various contributions in future volumes. Also contemplated is a recognition of the less active areas of psychology and of peripheral fields that are beginning to influence research.

These annual reviews are of inestimable aid to students, researchers, and professional workers who seek to keep abreast of the specialized literature, for they are not a mere abstracting service, but a critical evaluation of material not otherwise obtainable in a single volume.

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THE CHILD AUDIENCE.—A REPORT ON PRESS, FILM AND RADIO FOR CHILDREN. By Philippe Bauchard. (U.N.E.S.C.O. Publication, Paris.) United States Distributor: Columbia University Press, New York City. 1953. 198 p.

Philippe Bauchard, a French press and radio specialist, has compiled a valuable book about the present state of certain media of communication. He has reviewed those media which are directed toward a child audience and which are believed to have an influence on children. These findings are contained in the publication under review, which is a part of the U.N.E.S.C.O. series of studies on "Press, Films, and Radio in the World To-day."

Out of the study, Professor Bauchard has formulated a set of informative, interesting conclusions relative to the effects that each of these media has upon children. He states, for example, "... in truth, strange as it may appear, we are forced to admit that we know almost nothing about what affects the child. . . . To try to safeguard children without knowing what really endangers them, to set out to please them without knowing their tastes or understanding their development processes, is to court failure."

Consequently he invites groups to originate research into the various causes and motivation of children's behavior and offer its findings to the world.

This examination of press, film, and radio activities for children is interesting, and one is impressed with the apparent universality of the subject matter that is produced for youthful audiences every-

where. Little has been written on this topic before, and this makes the current publication very welcome.

The book, in addition to examining the various media in the twelve nations studied, also reviews legislation on them and the activities of various bodies in dealing with problems connected with them.

Many varied types of information are included in this report, and it should be helpful to parents and persons who work with children, for the specific information that it contains.

EDWARD LINZER

The National Association for Mental Health

SCIENCE AND MAN'S BEHAVIOR, THE CONTRIBUTION OF PHYLOBIOLOGY. By Trigant Burrow, M.D., Ph.D. New York: Philosophical Library, 1953. 564 p.

The first section of this book contains excerpts from a correspondence between Trigant Burrow and about thirty scientists in regard to the thesis contained in his earlier publication, *The Neurosis of Man*, published in 1949. A reprinting of the latter book[1] is also included. At a time when its publication had been delayed owing to post-war upheavals in England, the author sent advance chapters to investigators in various fields of science, among them Gordon W. Allport, A. J. Carlson, Kurt Goldstein, Leland E. Hinsie, Clyde Kluckhohn, Gardner Murphy, and Nicolas Rashevsky. Their questions, comments, and criticisms, together with Dr. Burrow's answers, are grouped in relation to distinctive aspects of his thesis, for example, his concepts of "normality," of the "social neurosis," of the "right-wrong" dichotomy, of the physiological implications of interrelational dysfunction. Elaborative remarks give continuity to the correspondence and add to the clarification of the issues under discussion. Dr. Burrow drafted the key chapters, and outlined the remaining sections. These, after his death, were ably edited and completed by William E. Galt, who was associated with Dr. Burrow for many years in his phylobiological researches.

As in previous publications, Burrow emphasizes in this book the global nature of man's conflict. He considers neurotic disorders as both indicators and expressions of a general defect of adaptation, and stresses the need of investigating this faulty constellation as it exists in the social reaction-average as well as in the clinically neurotic individual. From the background of intensive work with individual patients, and especially from the basis of his group-analytic studies, which he introduced around 1920, he undertook to determine the

[1] Reviewed in MENTAL HYGIENE Vol. 35, pp. 125–28, January, 1951.

common denominator to which clinical pathology and "normal" destructive trends, expressed in their extremes as delinquency and war, could be related. Insisting on the inclusion of the observer's own reactions, he participated with his students and patients in the examination of behavior as it occurred in the socially interwoven dynamics of the immediate moment.

In this social laboratory setting, habitual mood interchanges as well as neurotically elaborated defense mechanisms were submitted to painstaking and inclusive investigation. Features such as hostility and authoritarian self-assertion, submissive maneuvres and rationalizing evasions, socially corroborated affect-projections and other expressions of impaired communication, were brought to light and appraised as parts of a generally pervasive behavior-defect.

In Burrow's findings, individually conditioned responses to specifically unfortunate childhood experiences or to cultural stresses are not the major causative factors in disordered behavior. Rather he relates the disorder to a generic internal defect which is typically human and which developed with the emergence and inappropriate use of image, symbol, and language. This misuse of essentially positive capacities has resulted in a mischanneling of organismic processes, in false self-reference, and an internal disequilibration that is regarded as a powerful source of personally and socially disruptive processes.

These and other aspects of Dr. Burrow's thesis are discussed in his correspondence with the scientists. There is throughout this exchange a positive and constructive note. While the author is uncompromising in his indictment of the social neurosis, of the inveterate "rightness" of the "I"-persona and its social systematization, he views these disintegrative trends from the background of man's inherent integrity and of his basic capacity for social or phylic cohesion. His aim is "directed toward developing a technique through which man can overcome the partitive obstructions that now block his clear, whole feeling." From this broader phylo-organismic perspective two behavioral patterns are demarcated that cut across traditional classifications: the constellation of ditention, dominated by the autocratic self-image, is distinguished from cotention, constituting the organismically integrated type of orientation.

In these days of world crisis, Dr. Burrow's book is a strong plea to man to face his self-destructive plight and to take steps toward his own rehabilitation. "There are indications to-day," he says, "that man has reached a stage in his evolution when he *can* change his behavior as a race or species through conscious recognition of his own disordered processes." On this hopeful outlook Professor R. W. Gerard comments: "I am profoundly convinced, as you are, that 'human nature' can be changed in certain important aspects" (p. 43). It is Burrow's

position that this change cannot be restricted to symptomatic amelioration. Scientific ingenuity and method are to be directed to basic and community-wide causations. In this way man may come to take an active and constructive hand in guiding his own evolution.

HANS SYZ

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READINGS ON MARRIAGE AND FAMILY RELATIONS. Edited by Arthur Robert Olsen, with Case Studies by Emily Hartshorne Mudd and Hugo A. Bourdeau. Harrisburg. The Stackpole Company, 1953. 465 p.

In view of the vast literature available on this widespread topic, a book of selected readings has much to offer. The relationship of the study of marriage and family relations to the many and varied professions that impinge upon and influence it is well illustrated in the diversified selection of readings. Selections from the literature of psychology, anthropology, sociology, philosophy, religion, fiction, and even from ancient Greece, should prove a reminder that this is not, and cannot be, an isolated area of study directed by the dogma of one particular professional group. In recognition of this, and in the intelligent selection of readings used, lie the book's greatest merits.

With some exceptions, the selections are applicable and edifying. A few of them did not seem pertinent to the needs of the student not preparing to specialize in this field. For instance, the reading on kinship organization in Japan is of little practical value to the college student primarily interested in preparation for his own marriage in this country. Similarly, while the problems of inter-ethnic marriage warrant consideration, a reading might have been selected that would have been more meaningful to an American student than the one used. The subject of this reading was American-Panamanian marriages on the Isthmus, the selection stressing the fact that this would not be typical of the usual inter-ethnic marriage in the United States. With minor exceptions, however, the readings were pertinent, interesting, and diverse.

Possibly a different arrangement of the material presented would have improved the book. Until one becomes accustomed to it, the sequence followed in each chapter tends to be confusing. Chapters are divided into subheadings. Under each subheading is presented first the author's discussion of the topic. This is followed by his brief comments about the illustrative readings pertaining to that particular topic. Following a consideration of all the sub-topics in the chapter

are the readings themselves. Understanding of the significance of the readings might have been facilitated for the reader by placing the readings under the pertinent headings immediately after the comments made about them.

This minor point was particularly true in reference to the case studies, which were included at the end of each chapter. Frequently, the case studies seemed to be isolated in thought from the remainder of the chapter. If the case study had immediately followed the discussion, and especially its own introduction, the point it illustrated would have been much clearer, although in some instances even this would not have helped, for occasionally the case studies were too remote in meaning from the balance of the material in specific chapters to be quite relevant. As an example, in the chapter, *Parental Family Living and Its Impositions,* the case study is on the sub-topic, "Give and Take in Parent-Child Relations." The case study used showed a personality clash in marriage, being specifically related to neither chapter title nor subheading. Nevertheless, the use of case studies supplied by an established marriage-counseling agency makes a decided contribution to the book in interpreting theory in the light of actuality.

All of the subjects included in the book should be of value to the student seeking a broader understanding of marriage and family life, and there is a tremendous range of subject matter. Beginning with a general consideration of the family, the reader is given a picture of family life from mate selection through courtship and parenthood, even including such crises as death and divorce. By no means a comprehensive coverage of all aspects of marriage and family relations (there is little reference to sex adjustment, for instance), the book should acquit itself well as a supplemental text. Although written primarily for college students, it may be used to advantage by others who wish to "sample" in this broad field of interest.

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THE PSYCHIATRIST, HIS TRAINING AND DEVELOPMENT. Washington, D. C.: The American Psychiatric Association, 1953. 214 p.

This book describes the Conference on Psychiatric Education held at Cornell University, June 19-25, 1952.

The object of the conference was to develop and promote the best possible program for training residents in psychiatry. This task was undertaken by 86 members of the conference, including teachers in psychiatry, neurology, neuropathology, medicine, public health, and preventive medicine; administrators of mental hospitals; and repre-

sentatives of certain medical organizations. It should be specified that in their professional work the member psychiatrists of the conference were specialists in different sub-specialties—child psychiatry, military psychiatry, forensic psychiatry, industrial psychiatry, psychoanalysis, administrative psychiatry, and other specialties.

This impressive gathering deliberated for five and a half days on material—"facts, opinions, and recommendations"—worked out by preparatory commissions and distributed to all members a few weeks before the conference.

The subject matter of the conference included the following topics: the history, development, and present status of graduate training in psychiatry; the development and formulation of psychodynamic principles in modern psychiatry; community needs—social and economic factors—in relation to residency training; the recruitment and selection of candidates, and the personal problem of the resident in training; psychiatric training centers and facilities; ideals and practices in residency training; the rôle of psychoanalysis in psychiatric training; the rôle of child psychiatry in psychiatric training; other fields in psychiatric training (administrative, industrial, military, civil defense, and psychosomatic medicine); and psychiatry's part in the training of internists, pediatricians, and other physicians.

The outstanding feature of the conference was the effort made—for the sake of achieving positive results—to emphasize points of agreement rather than disagreements, notwithstanding the marked differences in the basic concepts of psychopathology and treatment held by the active participants. The broad-mindedness that prevailed can best be illustrated by the discussions on "psychodynamics" and on "the rôle of psychoanalysis in residency training."

There was, of course, full agreement on the importance of the psychodynamic aspect in the training of competent psychiatrists. Also, as was to be expected in such a gathering, there were among the participants those who had essentially different understandings of the meaning and scope of psychodynamic theories and concepts. The report of the commission on psychodynamics to the plenary session of the conference was, therefore, met with numerous criticisms. Yet the report was accepted "as representing at least a fair beginning in desirable effort to delineate what psychodynamics is all about."

Agreement and realistic judgment also prevailed in regard to the place of psychoanalysis in residency training. Both the commission on psychoanalysis and the conference reached "virtually unanimous agreement that *'it is not necessary to be psychoanalyzed in order to develop competence as a psychiatrist, including competence in psychotherapy and psychodynamics.'* " This statement received the blessing of no other an "anti-analyst" than Karl A. Menninger, whom the editors of this volume quote as follows:

"I applaud this statement that one does not have to be psychoanalyzed to be a good psychiatrist. You may think that it is obvious, but the residents don't believe it. And I don't know how you can convince them. I hope this statement will help, but I don't think it is enough.

"Not long ago, one of our better residents announced his intention of leaving the Menninger School of Psychiatry. We interviewed him and ascertained that his reason was: 'You don't believe in psychoanalysis. You seem to think that a man can be a good psychiatrist without being psychoanalyzed.'

"Now we have been accused for twenty-odd years of being so psychoanalytic that we are not good psychiatrists. So this is a curious dilemma —to be told by a resident that we are not psychoanalytic enough, and on the other hand to be accused by colleagues of being too psychoanalytic.

"There is a definite feeling on the part of a good many psychiatrists and psychoanalysts—particularly the latter—that you cannot be a good psychiatrist without being analyzed. This is one point of view, and one held strongly by a few. I don't believe it, and I am glad this statement contradicts it."

So far this review has been concerned with the procedures, decisions, and recommendations of the conference. To do justice to the achievement both of the conference and of the editors of this volume, it should be stated that it also offers substantial knowledge in the field of psychiatry.

The chapter on psychodynamics presents a concise, but rich-in-content survey of the science of psychodynamics. The uninitiated will learn a great deal, and the learned will have an opportunity to reflect upon principles of psychological mechanisms and psychotherapy.

The final chapter—*Supplementary Statements on Control and Methods of Training*—contains expressions by individual members of their ideas and ideals about residency training and brief descriptions of the basic practices in different training centers.

The reviewer is particularly impressed—undoubtedly because of his own bias in regard to theories and practices in psychopathology—by the statement on the teaching of dynamic psychiatry (psychodynamics) on page 180. Concisely and very effectively, the author analyzes the respective merits of Freud's psychoanalysis and Meyerian psychobiology and their contributions to psychiatric knowledge. He forcefully advocates the soundness of eclectic training in comprehensive psychiatry—training that will encourage the residents "to study all of man," to acquire "basic grasp of psychiatric disorders," to become "thoroughly grounded in the fundamental methods of observation, examination, and diagnosis." Equipped with such broad knowledge, the resident will be better prepared to grasp the various theories and concepts of psychodynamics.

S. KATZENELBOGEN

St. Elizabeths Hospital, Washington, D. C.

A History of Psychoanalysis in America. By Clarence P. Oberndorf. New York: Grune and Stratton, 1953. 280 p.

It is hard to believe that a span of fifty years covers the period since the origin of psychoanalysis in this country. In this volume Dr. Oberndorf, one of the early participants in the movement, out of the richness of his own experience presents a lucid, easy-flowing story. In his modest way, he tells how the growth of psychoanalysis affected him, saying all too little about how much his own integrity contributed to that growth. To those of us who participated and still participate in the making of this history, there is a pervasive nostalgia in this story of the growth of an idea. The aches of isolation and rejection are forgotten, and the mellowness that comes from a sharing in something that is for the betterment of human beings persists. It is difficult to keep oneself from reminiscing when one knew well so many of the early leaders in the field.

In 1911, in the course on psychiatry that was given at the College of Physicians and Surgeons for six weeks, one afternoon was assigned to psychoanalysis. Dr. Brill presented that subject. It is hard to convey the reaction of the student body not alone to the lecturer, but to his topic. Let us graciously term it as silence, behind which was intense skepticism. This was typical of the state of psychiatry at the time and its attitude toward psychoanalysis. Many things have happened since then, some pleasant and some not so pleasant. Dr. Oberndorf lives through those periods and presents them vividly and with great understanding and extraordinary mellowness. He exemplifies a quality not unusual in our specialty—strong interest in many fields. That is inevitable, of course, because of the privilege we have of knowing people thoroughly through a long therapy, which is often necessary. One learns a great deal of man's activities as well as of the impulses that create them.

We have one criticism to make—egotistical, I am sure: that Dr. Oberndorf spends too little time on what the cross-fertilization of child analysis and child guidance has done in the way of leading to an acceptance of psychoanalysis in this country. It may be a carping criticism, but I am sure he would understand that we all compete in a fashion to express our gratitude for what psychoanalysis has done in furthering the study of man and his multiple interests.

I would supplement Dr. Oberndorf's contribution by the beautifully and philosophically expressed address of the president of the American Psychoanalytic Association on December 7, 1952. In this Presidential Address to the association, Dr. Robert P. Knight rounded out the past, the present, and the hopes of the future with regard to psychoanalysis.

Edward Liss

New York City

THE SOCIAL THEORIES OF HARRY STACK SULLIVAN. By Dorothy R. Blitsten. New York: William Frederick Press, 1953. 186 p.

These chapters are another reminder of the long road that a psychology much indebted originally to Freud has traveled since. Their main purpose is to suggest new horizons for social science, too, because Dr. Sullivan (1892-1949) was one of those who made a point of relating the problems of individuals to the social order in which people live, and who enriched his own understanding of that order by his clinical experience in psychiatry.

He departed from Freud by greatly subordinating (in some instances rejecting) the rôle of *libido* and by regarding social and cultural influences less as the *superego* against which *id* and *ego* fought so many losing battles than as a field wherein people might find each his special opportunities for self-fulfillment. Out of association with William A. White, Sullivan came to see how problems of mental illness light up many other aspects of behavior, too. To understand the full life course of the human organism, he learned, we must know physical, chemical, biologic, psychobiologic, interpersonal, and cultural factors. All of these are essential parts of that environment in which people realize their potential patterns as a whole. This is a long way from stopping with exclusive attention to the influences playing upon the child. Important as these undoubtedly are, the experiences of later years also count. So do the expectations and aspirations; but these can never be understood apart from the social systems in which they occur.

Hence, after some ten years of preoccupation with the mentally ill, Sullivan became convinced that "not such individuals, but complex, peculiarly characterized situations are the subject matter of research and therapy" (p. 21). Thus interested in how people interact with others in fairly typical situations, he came to define psychiatry as "a science of living under the conditions of a given social order" (p. 23). Because he could not see such conditions as dead mechanical forces, but rather as the setting for the give-and-take of living human beings, his psychology is known as "interpersonal." (Contrast the emphasis on these living interactions back and forth with the psychologies, *e.g.*, of economic determinism or of "unchangeable human nature." The distinction may well be regarded as a scientific support to faith in democracy.)

One illustration of how maturation depends on "the significant others in a person's environment" is the way a child does or does not get access to satisfactions whenever elders control such access. By manipulating this, they evoke insecurity—felt as anxiety—and concomitantly the need to maintain security or to avoid anxiety. They lay down the conditions that will remove frustrations and provide

both satisfaction and security (p. 46). The traditional view of the socializing rôle of reward and punishment, we see here, is expanded by adding the part played by the security needs felt even at a subconceptual level. "Culturally defined and interpersonally imposed patterns of behavior come to motivate people as imperiously as biologically determined requirements" (p. 53). Here, incidentally, is one origin of much resistance to social change. "Because of this integrating of cultural entities into human personality, so many people interpret present situations and anticipate future ones almost exclusively in terms of the past, however inadequate past experience may have become to meet current conditions" (p. 53).

It is from people that children and older individuals get languages, other symbols, stereotypes, personifications, and, no less, upbuilding motivations and ideals. The direction in which biologic urges are sublimated depends on the persons in the surrounding culture. Because we are subject to manipulation by anxiety, a democratic society has to make persons more aware of the part played by their unwitting anxieties and of the way to channel these off creatively. Surely, says Dr. Blitsten, "the qualities, knowledge, skills and freedom from anxiety that enable a person to observe social phenomena with clarity and to discern the implications to be drawn, deserve careful consideration and explicit formulation" (p. 173). More of this will be achieved when social scientists, therapists, educators, unite to bring our ever-growing modern knowledge home to the multitudes. Sullivan was so convinced of the need for these professional interrelationships that "he spent at least as much thought and effort on how to train personnel for all kinds of social investigation as on therapeutic . . . problems" (p. 173).

Time alone will tell how much can be garnered from these views of so earnest a student, or whether they are chiefly the individualized utterances of a thinker not always aware that his own preferred vocabulary may really be contributing little that is new to our knowledge of his subject matter. Sullivan's language seems at times needlessly involved, even though, to be sure, a scientist is committed to the strictest accuracy. The labels he attached to the words "coöperation" and collaboration" (pp. 91, 95) may be questioned. His Latin plural for "consensus" (p. 170) is in error. The author herself is correct in saying (p. 134): "It is difficult or impossible to convey any reasonably valid idea of political democracy, American style, to populations on the globe whose direct experience has included no elements that could be symbolically recombined by dint of verbal statements alone to evoke a conception of the meaning intended." But would anything be lost if she put this into the simpler, old-fashioned words: "People in other lands will grasp the meaning of

American democracy to the degree that they have experienced the realities that the words denote or symbolize"?

A Columbia Ph.D., Dr. Blitsten teaches at Hunter College, New York, in the department of sociology. Her knowledge of modern psychology makes one wish that specialists in the latter field were as much at home as she is in the social studies.

HENRY NEUMANN

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CHILD TRAINING AND PERSONALITY: A CROSS-CULTURAL STUDY. By John W. M. Whiting and Irvin L. Child. New Haven: Yale University Press, 1953. 353 p.

This book is an outstanding example of painstaking description and stringent self-criticism. The authors have attempted a project of a type that we hope will become much more familiar. The book is the report of a study whose aim was to answer two crucial questions: "First, do early experiences in the life of an individual have a persisting effect on his personality? Second, do the personality characteristics of the typical member of a society determine in a measurable way any of the beliefs and practices in that society?" (p. 305). The data utilized were extracts from already available ethnographic reports about 75 different primitive societies, with the addition of a reference group from the United States.

Let us say at the outset that this is distinctly *not* a book for those who expect help in dealing with the problems of individual children or for those who are primarily interested in the applications of scientific knowledge. It is, furthermore, not recommended for the amateur or the dilettante. This is a report of a type that is more often published in a monograph series, intended for a very restricted audience, or that is brought out in a much more condensed form.

"In all societies the helpless infant, getting his food by nursing at his mother's breast and, having digested it, freely evacuating the waste products, exploring his genitals, biting and kicking at will, must be changed into a responsible adult obeying the rules of society" (p. 63). This unlovely picture of the often romanticized life of the human infant states the empirical working foundations for the study. One may easily question the absolute nature of such a description, but that would not alter the essentials of the case.

One of the major virtues of this work lies in its construction of a theoretical framework and in a systematic adherence to it for the exploration of empirical data. The hypotheses tested are derived primarily from Freudian theory. The concepts by which they are expressed utilize the language of general behavior theory. Such a

procedure can produce a hybrid that will be stronger and more fruitful than either of its parents. The authors express their intention as follows: "The reinterpretation of psychoanalytic hypotheses in terms of general behavior concepts brings them into relation with a vast body of scientific knowledge about the determinants of behavior, and out of this new relationship may spring new principles which go far beyond and behind the original psychoanalytic hypotheses" (p. 14).

The data to which the theoretical framework is applied are from still another area of the social sciences—cultural anthropology. In this fact lies simultaneously the opportunity and the limitation of the whole study. No new data were collected. Rather, the method was to exploit and make productive data already on file for 75 primitive societies. The authors report that the amount of data on a given society varied from about one printed page to several hundred. The materials themselves were, obviously, not gathered with the specific purposes of this study in mind. But the areas studied were of the sort typically reported in ethnographic investigations.

Three judges were then provided with the questions that Whiting and Child wanted answered and were required to make ratings and rankings of the various societies from the materials given them. The opportunity of such a cross-cultural study lies in the number of societies taken into account. Marked limitations inhere in the many layers of variables intervening between the original parent-child situation and the final published statements of the book. Furthermore, we must assume wide variations in the quality of the ethnographic studies.

The five systems of behavior—oral, anal, sexual, dependent, and aggressive—were chosen on the assumption that they would occur in all societies. Judges were asked to make judgments concerning the initial satisfaction permitted in each of these areas; the degree of anxiety developed in the course of imposing inhibitory control; and judgments of the age of socialization. These judgments formed the basic descriptions of child training in the various societies that made it possible to approach their first major question of the persistence of the effects of early training on personality.

At this point, the authors make a very broad leap and utilize customs related to explanations of illness and to technique of therapy as indices of personality characteristics of the typical members of a given society. The rationale offered is that these customs are "a sort of projective test for a society as a whole" (p. 120), analogous to Rorschach or thematic-apperception-test fantasy productions for an individual. The relationship between early training and later personality is dealt with entirely in terms of generalizations about the society as a whole. This is not a book in which one will discover any

direct data bearing on the relationships between early child training and the actual development of individual personalities.

The heart of the book is the authors' modification of the Freudian concept of fixation, and elaboration of the concepts into a theory of negative and positive fixation. The term, "positive fixation," is used to refer to fixation that results from a high degree of gratification, while "negative fixation" is used to refer to that fixation which results from severe socialization. Whiting and Child interpret their data as evidence for the validity of the negative-fixation theory, but are somewhat more doubtful about positive fixation. Separate chapters are also devoted to more tentative explorations of the origins of guilt and of the origins of the fear of others.

Child Training and Personality should become a classic in the field of cross-cultural studies in which it pioneers. The authors have provided a thoroughgoing description of their work that will enable competent persons to check on it. They merit special praise for considering at length other possible interpretations of their data. We hope with the authors that their work will further application of psychological principles at the cultural level.

For the less dedicated reader, however, the involved accounts of method and interpretations may seem unendurably lengthy. The demands for extremely close reading will disappoint those who anticipate the sort of material more often found in books of similar titles. But the authors will not care, since the book was intended for specialists.

DOROTHY CLIFTON CONRAD

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PERSONALITY DYNAMICS: AN INTEGRATIVE PSYCHOLOGY OF ADJUSTMENT. By Bert R. Sappenfield. New York: Alfred A. Knopf, 1954. 412 p.

In the author's words, "this book is perhaps the first serious attempt to develop, in textbook form, a thoroughly systematic presentation of psychoanalytic principles." It is divided into 16 chapters, which deal with the principal dynamic phenomena, such as conflict, anxiety, repression, fixation, regression, displacement, projection, sublimation, reaction formation, rationalization, and so forth. Two chapters are devoted to the discussion of identification, in which the author makes a useful distinction between perceptual and developmental identification. The chapters are neatly organized, starting with the definition of the phenomena described and concluding with the discussion of its adjustive implications. These adjustive implica-

tions deal with the "applied psychology" of adjustment, the author prefers this term to what has traditionally been called "mental hygiene," which he feels may be misleading. The term "implies merely the application of adjustive principles to the problem of everyday living." At the end of each chapter, there is a very good summary, as well as a list of suggested readings.

The dynamic concepts of psychoanalysis are well presented and are richly documented by extensive quotations, particularly from Freud, but also from Horney, Alexander, and other analysts, as well as from the writings of dynamically oriented psychologists, such as Murray, Rosenzweig, Dollard, Mowrer, Symonds, and others.

The subtitle of the book, which claims an integration of the material, is, however, somewhat misleading. There is actually no real integration of data under some original unifying concept, but largely an accurate, almost compilatory presentation of existing conceptions. Although the author considers his work as an integration of psychoanalytic dynamics with an organismic conception of behavior, the views of the main exponents of the organismic approach to the study of personality are either only briefly mentioned or entirely omitted.

The chief value of the book lies in the well-documented, systematic presentation of the most important dynamic concepts. Because of this it is very useful as a reference book for students of psychology. The book is clearly and skillfully written, which makes it pleasant reading. The reviewer feels that it can be used profitably also as a textbook, if supplemented with a text on methods of personality studies, and some text that supplies the student with clinical case material.

ALICE F. ANGYAL

Boston, Massachusetts

NOTES AND COMMENTS

Mental Health Week—1955

The dates for observance of the 7th annual Mental Health Week have been set for May 1–7, 1955. As in past years Mental Health Week activities across the country will be directed by NAMH, with the National Institute of Mental Health as co-sponsor. Many national organizations are again planning special programs to mark Mental Health Week. Packets of publicity materials and suggestions will be prepared by NAMH for use by mental health associations and other groups which are taking part in the observance.

NAMH Fourth Annual Meeting

More than 400 people from all parts of the country attended the Fourth Annual Meeting of NAMH, which was held in New York City from October 22–25.

Focusing on the theme "Mental Health—The People Act," the Conference featured many panel discussion and idea-exchange sessions at which everyone was invited to participate, as well as more formal programs featuring talks by well-known authorities from mental health and related fields.

One of the highlight events was the Annual Banquet, at which the major address was presented by Dr. Alan Gregg, Vice-President of the Rockefeller Foundation, who gave the talk "The Rôle of National Associations" which is printed in this issue of Mental Hygiene.

Richard Weil, Jr., NAMH President, in presenting his annual report at this time, called attention to the fact that mental illness took a greater toll during the past year than ever before. While noting that there were many gains during the year in the care and treatment of the mentally ill and in the prevention of mental illness, Mr. Weil asserted that "these gains were in the nature of a rear-guard action against the inexorable advance of a mammoth foe."

At the Research Luncheon session, Dr. Winfred Overholser, Superintendent of St. Elizabeths Hospital and Chairman of the Committee on Schizophrenia Research of the NAMH, gave a summary of the contributions made during the year ending June 30, 1954. Dr. Overholser said that it is now definitely known that the development and progress of schizophrenia is dependent upon three major sets of factors: "(a) a certain constitutional weakness which some children bring with them into the world and which makes them particularly vulnerable in their adjustment to life stresses; (b) certain types of stress situations, particularly those occurring in early life, that are

apt to be especially damaging in cases of such constitutional predisposition; and (c) damage both psychological and physiological, which is caused by the interaction of 'a' and 'b' and which results in the symptoms of the disease and its perpetuation." Isolation of these factors, Dr. Overholser said, has now made it possible to contemplate devising a program of prevention.

The Keynote Luncheon featured an address by Albert Deutsch, newspaperman and author, who delivered a talk on "The Stirring of the States Against Mental Diseases." Other sessions included one dealing with the emotional problems of childhood, adolescence and old age, with panelists Gladys Gardner Jenkins, authority on child development; Dr. Frances E. Wilson, Director of Guidance, New York City Public Schools and Dr. Jack Weinberg, Assistant Professor of Psychiatry, University of Illinois. Dr. Kenneth Clark, Associate Director of the North Side Center for Child Development, New York City, presented a report on "The Impact of Racial Segregation on Mental Health" and Dr. Robert H. Felix, Director of NIMH, spoke on "New Hope In the Fight Against Mental Illness."

An Open Letter to Relatives of the Mentally Ill

A patient in one of the California State hospitals wrote the letter which follows. It was reproduced in a mimeographed *Report to the Governors Council* put out by the State of California Dept. of Mental Hygiene with the introductory notation "It speaks eloquently for itself." It does indeed!

"This is a letter to you, the mother who has a young son on A-7—to you who have a brother on T-14—the wife who has a husband in Phillips Cottage—to you parents who have a youngster on C-1.

"This, above all, is not a letter of reproach. It is only a letter from a patient who has observed, over a period of time, the big difference a letter or a visit from a relative can mean to one confined in a mental hospital.

"Although there are a certain number of volunteer patients in every hospital of this type, the majority of the people are court-committed. As a rule, it is a relative that signs the papers committing a brother, sister, wife or son to the hospital. When the patient is in the beginning stages of recovery he is quite often resentful at being locked up, cannot make logic out of why he is here and becomes bitter toward the person who is responsible. Because of this, the first few visits you pay to your son or wife may not be happy ones, in fact, they may be most unpleasant. In the first place, you are extremely uneasy at entering a place where 'crazy people' live. Many of you are enlightened and do not feel this way, but there are still those

who in the back of their minds are very happy when they see the clock say 4 o'clock and visiting hours are over.

"As time goes on, the patient improves with therapy; you become acquainted with staff personnel and doctors; you begin to know certain of the fellow patients and realize there are some very nice friends to keep your relative company.

"If the son continues to improve, your visits are regular, there are 24-hour leaves, the 48 and the 72. All goes smoothly and perhaps there is soon the day of conference and you are notified he is well.

"However, unfortunately, all mental illness is not always easy to cure. The more marked symptoms are alleviated, but the delusions, hallucinations, and perhaps extreme tension remain. It is obvious that the patient is in no condition to once again take his place in society. You become discouraged and it is easy to say to oneself: 'I really don't have time to drive up to Napa this week-end, and besides he may scarcely talk to me if I do. I sometimes wonder if he doesn't even resent my coming. I'll wait and go next week.' But, somehow, next week sometimes comes up and you can't make it then either. Hope has gone and the incentive goes along. You neglect to write except on special occasions. And so it goes. There are the few and far between week-end leaves which become an increased strain on the family life. Then you rationalize by thinking it is really better if he stays up there, he is adjusted and doesn't seem to unhappy at being there.

"How can I tell you—it is not the visits, the letters, the packages, that make the difference—it is the knowledge that someone still cares, that someone still believes in you, that someone still has hope that you can 'come back.' It can mean the actual difference between getting well and continued regression, in some cases. In others it can only be that you make life a little more real—that you do not let him escape entirely into that other world. Continued letters, visits can be a tentacle of reality, reaching out, and can be the help that will turn the trick. Something all the doctors in the world cannot offer.

"Call it love therapy or whatever you will, it is the oldest and best medicine in the world. Only you can give it. It is your privilege and responsibility."

APA Mental Hospital Institute

Focusing on the theme "The Psychiatric Hospital as a Community Resource," The American Psychiatric Association held its Sixth Annual Mental Hospital Institute on October 18–21 at Hotel Nicolette in Minneapolis. In numbers far exceeding previous years, the 400 delegates included hospital superintendants and a wide range of other staff specialists, governmental authorities and representatives

of numerous national agencies and organizations working in the mental health field. A variety of well-chosen and timely topics made up the four day program and elicited enthusiastic give-and-take discussion from those in attendance. An upsurge of interest among hospital administrators was shown in topics with which mental health associations are also much concerned, such as: "Community Planning for Mental Health"; "Good Practices Keep Good People"; "Use of Volunteers in Mental Hospitals"; "State Surveys of Total Mental Health Surveys"; "Sources of Information and Assistance to Hospitals"; and "Contributions of Professional Personnel other than Psychiatrists."

In these and other sessions delegates demonstrated repeatedly an appreciation and eagerness for growing cooperation with and aid from all appropriate community resources including citizens' mental health associations. In this latter regard, singularly significant was the choice of toastmaster for the Institute's Annual Banquet, a role well filled by Rev. Frederick M. Norstad, president of the Citizens' Mental Health Association of Minnesota.

NAMH was enrolled for the entire Institute and was among eight national groups invited to describe their services and activities at the session on "Sources of Information and Assistance to Hospitals." From these combined reports it was a revelation to recognize the wealth of concerted energies mobilized for the past few years on the problem of mental illness and a stimulation to anticipated accelerated progress as all concerned groups more fully come to understand and utilize one another's special talents and direction of activities.

NAMH's exhibit was maintained with the help of Max Williamson, Executive Director of the Citizens' Mental Health Association of Minnesota. This opportunity for delegates to examine NAMH materials and to discuss program activities with our representative proved mutually valuable. A notable interest was shown in materials on volunteer programs and in the variety of media useful in community education.

This year's Institute was unquestionably the best by far over any previous year, both in focus and content of program and in its smooth operation planning. Next year the Institute will convene in Washington, D.C. where it will coincide with the centennial observance of the founding of St. Elizabeths Hospital.

PAUL HARRIS

BEHIND SCENES AT MENTAL HOSPITAL TELEVISED

Network television cameras entered a mental hospital for the first time when NBC's "March of Medicine" program was telecast from Hudson River State Hospital (N.Y.) on Sunday, October 31. The

half-hour program, entitled "Search for Sanity," was the first in a new series produced and sponsored by Smith, Kline & French Laboratories in cooperation with the American Medical Association.

The program showed Ben Grauer, of the NBC staff, being taken on a tour of the hospital by Miss Audrey Cole. Along with Mr. Grauer, viewers saw dormitory, treatment rooms and day rooms. The purpose of various facilities such as insulin and electric shock therapy, psychotherapy and other facilities which are used to help the mentally ill in hospitals were explained. A dramatic high spot of the program was the revelation by the attractive Miss Cole that she had been a patient at the hospital.

Asked what she would like to say as one who had been mentally sick and recovered, Miss Cole stated: "What I want most is to tell people not to fear mental diseases; to get help when they need it and to please change their attitude about mental illness." She concluded with the plea that mental diseases be regarded as "respectable" as any other disease.

The telecast also included an interview with Dr. Leo Bartemeier, Chairman of the Committee on Mental Health of the AMA and past president of the American Psychiatric Association.

NAMH awarded special citations to Smith, Kline & French and the AMA for this excellent program. Award ceremonies were held December 7th at the Annual Meeting of the Southeastern Pennsylvania Association for Mental Health. Mrs. Felix duPont, Jr., NAMH Board member, presented the awards. Dr. Bartemeier accepted the citation for the AMA and Mr. Francis Boyer, president of Smith, Kline & French, accepted for his firm.

NAMH is making available on loan kinescope prints of this program for community showings at meetings or public programs.

Dr. Brock Chisholm Addresses NAMH Benefit Dinner

Much of the international conflict of today stems from the emotional insecurity of the people in each nation, Dr. Brock Chisholm, psychiatrist and former Director General of the World Health Organization, told guests at a dinner held November 8th at the Waldorf Astoria in New York for the benefit of the National Association for Mental Health.

The reason there is so much insecurity today, Dr. Chisholm explained, is that the conditions of survival are changing so rapidly and so frequently within a single generation that the individual is unable to make the necessary psychological adjustment. "The old ways" of reacting to life's stresses are completely outmoded and the individual does not have the opportunity to adopt "new ways" for

long because they too become obsolete in a very short period of time, he said.

This situation, Dr. Chisholm declared, produces individual feelings of insecurity which in turn hinder the "adoption of new and more appropriate methods of establishing satisfactory human relations locally, nationally or on a world basis.

"There must be a relatively high degree of mental health amongst the individuals of any group in order that that group—whether social, racial, religious, national or international—may react maturely and effectively to new circumstances. Without that high degree of mental health when traditional patterns are not proving effective, reactions may be violent or extreme because under the pressure of deep anxiety."

Dr. Chisholm also stated that the mental health movement, working to strengthen the mental health of people of all nations, is "one of the greatest forces acting in the direction of harmonious living and world peace."

Other participants on the evening program were: Dr. Arthur Compton, Civilian Aide to the Secretary of the Army and former Technical Advisor to the UN Atomic Energy Commission; Dr. Harlow Shapley, Prof. of Astronomy at Harvard Univ., Walter Abel, screen and TV star, Tex McCrary and Jinx Falkenberg, well-known team of radio-tv programs; Dr. William Menninger, The Menninger Foundation, and Dr. John R. Rees, Director, World Federation for Mental Health.

The benefit affair was planned and sponsored by Mrs. Henry Ittleson, NAMH Vice-President.

Indiana Opens Clinic for Mentally Retarded Children

Practically everywhere in the country the need for more child guidance clinics is cited whenever problems related to the mentally retarded are discussed. Indiana has taken a step toward meeting this need with the opening of its first statewide out-patient child guidance clinic.

Alfred Lasser, Jr., Superintendent of the Muscatatuck State School which is conducting the clinic, announces that parents will have the following kinds of facilities and services available for their children: medical, psychiatric, psychological, social work, speech and hearing, special education and vocational services. Clinic services for diagnosis and evaluation will include interviews and testing. Referrals will be made, after evaluations have been completed, to specialists and agencies indicated. Parent guidance under supervision of the Social Service Department will be included for the benefit of families. The

Clinic will be open once a week and will receive patients by appointment only.

First Meeting of AMA Mental Health Committee

The first conference of the American Medical Association's Committee on Mental Health was held in Chicago during September. Thirty-five State Medical Societies were represented to encourage closer relationships among general practitioners, psychiatrists and other specialists. Most of the representatives were chairmen of State Medical Societies' Committees on Mental Health.

The conference considered such matters as alcoholism, advances in mental hospital care, the part psychiatric societies can play locally in cooperating with state and county medical societies and how the Women's Auxiliaries to the AMA can cooperate with the local medical committees on mental health.

AMA Auxiliary

The American Medical Association's Women's Auxiliary, which has over 62,000 members, has chosen mental health as its special project for the coming year. This representative group of women should prove a powerful force for helping to rally public support for mental health programs across the country.

Use of Closed-Circuit Television in Mental Hospitals Being Studied

Television is now being investigated as a means of presenting psychotherapy to a large audience. A research project has been started at Agnews State Hospital by members of the hospital staff and the San Jose State College Psychology Dept. The study will attempt to find ways in which closed circuit television can enable psychiatrists to make contact with a large number of patients at one time.

Psychologists at San Jose studying reactions to commercial television at Agnews, noticed that formerly uncommunicative patients would sometimes talk back to the televsion receivers. It was thought that if commercial programs could bring patients back to contact with reality where other means had failed, there was a possibility that TV could be used in direct therapy. A trial presentation took place at Agnews this summer and further studies of the possibilities of the new method of presenting psychotherapy are being made at the hospital.

A New Kind of Volunteer Services Program

Modesto State Hospital in California has initiated a new kind of volunteer program where the emphasis is on activity in the community rather than just in the hospital. The hospital plans to recruit several hundred volunteers who are willing to take patients into the community for special activities. "We have felt for several years that a plan such as this was more practical than just a volunteer program in the hospital itself," a hospital spokesman declares. "We feel that taking patients into the community while they are still in the hospital will enhance their adjustment when placed on leave and hasten their discharge."

An example of this kind of program is cited by the hospital: The Modesto Tennis Club offered to teach patients to play tennis. While there were between 20 to 30 patients who indicated they would like to play (and who could benefit from the activity) the hospital suggested that tennis club members work with the patients at their own club, where the patients could mix with other groups of people who were also learning to play.

Modesto is also encouraging selected housewives to take patients into their homes one day a week. The patients on these visits would be exposed to home life as much as possible. The plan would be to treat the patient as an ordinary member of the family and to encourage him to take part in the routine of living.

New Clinic Center in the Bronx

A new clinic center has been opened in the Bronx (New York) as part of the reorganization of the After-Care Services of the New York State Dept. of Mental Hygiene in the metropolitan New York area.

The Bronx Clinic Center is the second of four to operate under the expanded program of the psychiatric and social services of the Department for patients on convalescent care from state mental institutions.

In announcing the new clinic, Dr. Newton Bigelow, Commissioner of Mental Hygiene, explained that the expansion and reorganization of After-Care Services in the metropolitan area was undertaken to prevent duplication of service and to make more effective use of the services of psychiatric social workers. Under the new system, social services in the After-Care Clinic will be centralized and furnished directly to patients from the clinics in the borough in which they reside. Patients released from state mental hospitals are placed on convalescent status under the Department's After-

Care program for a period follow-up until deemed ready for final discharge.

Each clinic has its own permanent staff and administratively is completely separate from institutions.

Special Fellowships to Psychiatrists Offered

Availability of a limited number of fellowships to psychiatrists who are interested in the emotional problems of the physically handicapped (particularly those of the poliomyelitis patient with respiratory difficulties) has been announced by the National Foundation for Infantile Paralysis. In order to be eligible for these fellowships, physicians must have completed two years graduate training in psychiatry acceptable to the American Board of Psychiatry and Neurology; be a U. S. citizen (or applicant for citizenship) and be in sound health.

The applicant must propose a program of study to be undertaken in a center concerned with rehabilitation of the physically handicapped, which has affiliation with an approved Department of Psychiatry. The training of the Fellow in the application of psychiatric concepts and methods to the treatment of the physically handicapped must be supervised by the Department of Psychiatry. An opportunity for working with polio patients with respiratory disease should be available.

Selection of candidates is made on a competitive basis by the National Foundation's Clinical Fellowship Committee. Appointments will be made for one year but may be extended upon recommendation of the Committee. Applications received by March will be considered in May; if received by September 1, they will be reviewed in November. Financial benefits will be determined by marital status and number of dependents. Stipends range from $3,600 to $7,000 a year.

For additional information and application forms, address the National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

Leader Training Sessions Planned

Two three-week summer laboratory sessions for training leaders in the skills and understanding necessary for developing effective groups have been announced by the National Training Laboratory in Group Development at Gould Academy, Bethel, Maine. The sessions will be held from June 18 to July 8 and from July 17 to August 5.

Approximately 120 applicants will be accepted for each period.

Persons involved in the problems of working with groups in a training, consultant, or leadership capacity in any field are invited to apply.

The training program is organized so that each training group can use its own experience as a laboratory example of group development. Group skills of analysis and leadership are practiced through the use of role playing and observer techniques. Concentrated clinics give training in the skills of the consultant and the training in human relations. Training groups explore and experience the role of the group in the larger social environment in which it exists. Finally, a major portion of the last week of laboratory is spent in specific planning and practicing the application of laboratory learning to back home jobs.

The National Training Laboratory in Group Development is sponsored by the Division of Adult Education Service of the NEA and by the Research Center for Group Dynamics of the University of Michigan, with the cooperation of faculty members from a number of universities and other educational institutions. Further information may be obtained from the National Training Laboratory in Group Development, 1201 16th Street, N.W., Washington 6, D.C.

Specialized Training Available at AAPCC Member Clinics

Specialized training in child psychiatry is available in a number of member clinics of the American Association of Psychiatric Clinics for Children, the association has announced. The training begins at a third-year, postgraduate level with minimum prerequisites of graduation from a Class A medical school, an approved general or rotating internship, and a two-year residency in psychiatry, approved by the American Board of Psychiatry and Neurology.

Fellows receive instruction in therapeutic techniques with children in out-patient settings, which utilize the integrated services of the psychiatric clinic team. Most of the clinics have a two-year training period although a few will consider giving one-year training in special cases, the AAPCC reports.

Fellowship stipends are usually in line with the U. S. Public Health Service's standards, that is, approximately $3600, as these stipends come mainly from the Public Health Service. Special arrangements may be made occasionally to supplement the stipends by taking on other responsibilities locally (e.g. part-time work with the V.A., consultation to social agencies, etc.)

The AAPCC acts as a clearing house for applicants. Application may be made through its office, or directly to the individual clinics. In all cases, acceptance of applicants for training is made by the individual training centers. For further information and application forms, write: Miss Marion A. Wagner, Administrative Assistant

American Association of Psychiatric Clinics for Children, 1790 Broadway, Room 916, New York 19.

First "Community Health Week" Planned

The first nationwide observance of Community Health Week will be held March 21 through March 27, under the sponsorship of the U. S. Junior Chamber of Commerce, in cooperation with the National Health Council, of which NAMH is a member. The theme will be "Know Your Community Health Resources." Jaycee chapters have been asked to name local Community Health chairmen and to get in touch with local health leaders to help plan and carry out Community Health Week activities. National Health Council member organizations with active community programs are urging local and state affiliates to cooperate with plans for the week. Events suggested by the Jaycees include health fairs and forums, special editions of local newspapers, open house in official and voluntary agencies, television and radio programs, and various school health projects.

Announcements of Meetings

The American Orthopsychiatric Association will hold its 32nd Annual Meeting at the Hotel Sherman in Chicago on February 28–March 2, 1955. Approximately 100 scientific papers will be presented by psychiatrists, psychologists, social workers, educators, sociologists and anthropologists. There will be all day sections on Childhood Schizophrenia, Child Development and Psychotherapy with Children. Visual material of specific use in mental health education will be presented for two days of the meeting. Twelve workshops are being planned and numerous technical and commercial exhibits will be on display.

Inquiries about program, reservations, exhibits, or other matters should be directed to Dr. Marion F. Langer, American Orthopsychiatric Association, Room 411, 1790 Broadway, New York City.

The 1955 National Health Forum will be conducted March 23–24 at the Hotel Sheraton-Astor, New York City.

The general theme will be "Forecasting America's Health" and sessions will include talks and discussions on how health planning will be affected by economic trends, atomic developments, new directions in governmental programs, the march of medical and social science, the demand for and costs of medical care; case studies in interaction on "Tomorrow's Unity Problem X, State Problem Y and National Problem Z," and "Health Career Horizons"—a report on health manpower. The annual forum is sponsored by the 48 national organizations which are members of the National Health Council.

Copies of the advance program and reservation blanks will be available from the National Health Council, 1790 Broadway, New York 19.

The American Personnel and Guidance Association has announced that its 1955 national convention will be held in Chicago, April 3 to 7, at the Conrad Hilton Hotel. Theme of the meeting will be "Guidance and Personnel Work in a Dynamic Society." The keynote speaker will be Dr. Gardiner Murphy, Director of Research, at the Menninger Clinic. Further information may be obtained from Nancy Wimmor, Publicity Chairman, 57 West Grand, Chicago 10.

Recent Publications

Many hospitals have to contend daily with the fears of very small children towards their first hospitalization. In order to prepare children—and their parents—for this eventuality, the Children's Medical Center in Boston has compiled a delightful booklet entitled "Johnny Goes to the Hospital." Written by Josephine Abbott Sever, it tells the whole story of three-year-old Johnny's stay at the hospital (including the less enjoyable aspects of the experience) in words simple enough for a child to read, or to understand when it is read aloud to him. The text has been authenticated by the staff of the Children's Hospital and a section of notes to parents is included. Charming four-color illustrations by Mary Stevens bring the story to life. For any child aged three to eight, this book will make the hospital no longer a frightful place, but an interesting and busy spot. It has been endorsed by members of the NAMH Education Committee and is available from NAMH, 1790 Broadway. The price is $1 per single copy, 75¢ for six or more.

The Group for the Advancement of Psychiatry has recently issued a publication entitled "Integration and Conflict in Family Behavior." This report is the first of a series being prepared by the Committee on the Family on the relation between the family and the mental health or illness of the individual, Dr. Walter E. Barton, GAP President, explains. The general question being asked in all the reports is whether one can distinguish various states or conditions in the family which are either hostile to or promote the healthy adjustment of the individual, Dr. Barton writes.

The first report proposes a method for dealing with this question. The method consists of defining the social roles of the members of the family in accordance with the values arising from the cultural background of the family. So defined, the roles are then matched and analyzed for the degree of integration or conflict which inheres in them. In this way, family problems can be related rather precisely

to cultural conflicts, on the one hand, and to the emotional problems of the individual on the other.

Copies of this report (GAP Report No. 27) may be obtained from the Group for the Advancement of Psychiatry, 3617 West Sixth Ave., Topeka, Kansas. The price is 50¢.

The proceedings of the National Conference on Juvenile Delinquency, called by the Secretary of Health, Education and Welfare and held in Washington on June 28–30, have recently been published. The report discusses the problem in terms of civic action, state legislation, the police, the schools, the courts, parents' roles, etc. The proceedings are on sale by the Superintendent of Documents, Washington 25, D.C. at a price of 25¢ per copy, with a discount of 25% on orders of 100 or more. Also available is a portfolio of materials which should be helpful to groups planning a meeting or conference on delinquency. Requests should be addressed to the Special Juvenile Delinquency Project, c/o the Children's Bureau, Washington 25.